The Queer Sexual Citizen: Bisexual and Queer Young Women's Sexual Health in Tasmania

By

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Declaration of Originality

This thesis contains no material which has been accepted for a degree or diploma by the University or any other institution, except by way of background information and duly acknowledged in the thesis, and to the best of my knowledge and belief no material previously published or written by another person except where due acknowledgement is made in the text of the thesis, nor does the thesis contain any material that infringes copyright.

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This research has been approved by the Tasmanian Social Sciences Human Research Ethics Committee (Ref: H15217)

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Statement of Co-Authorship

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Paper 2: Grant, Ruby and Meredith Nash (2018) 'Navigating Unintelligibility: queer Australian young women's negotiations of safe sex and risk.' *Journal of Health Psychology*.

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Abstract

Over the last three decades, the intersecting rise of neoliberalism and post-feminism has shifted how gender, sexuality, and citizenship are framed socially, politically, and economically in the West. At the same time, queer identities are becoming divorced from social movement politics and are increasingly situated in individualist rhetoric of "homonormativity." Yet, few sociological studies examine queer young women's identity politics in the context of post-feminism and homonormativity. Furthermore, bisexual and queer women's sexual health is absent from most mainstream Australian public health research, policy, and practice. The small body of Australian scholarship in this area focuses on urban experiences, despite the well-documented health disparities of rural populations. This thesis provides an in-depth, feminist sociological account of how rural Australian bisexual and queer young women negotiate identity, sex, and health. Drawing on qualitative interviews with 15 Tasmanian women, this thesis examines the following research questions:

1) How do Tasmanian queer young women conceptualise, negotiate, and experience identity, health, and sexual citizenship in the context of neoliberal post-feminism?
2) How does heteronormativity impact Tasmanian queer young women's experiences of "safe sex" and sexual health?
3) What are the effects of these experiences on the health-seeking behaviours and sexual health outcomes of Tasmanian queer young women?
4) How do healthcare providers accommodate these experiences through inclusive practice?

Using Jose Esteban Muñoz's "Disidentifications" (1999) as a theoretical framework, this thesis explores key themes of labelling sexual identity, negotiating "safe sex," and navigating rural sexual healthcare. I argue that while queer young women's reflexive identity and health politics are products of neoliberalism, their disidentifications offer scope for critical, queer sexual citizenship.

Introduction

When I came out as bisexual many met my identification with confusion. What experiences entitled me to claim that label? Why was I identifying this way when I was in a monogamous relationship with a man? Why didn't I describe myself using other plurisexual terms like "pansexual" or "queer"? And why was I identifying this way now? Implicit in these questions are assumptions and misconceptions about young women's experiences of bisexuality and sexual citizenship. These questions inspired me to think deeply about how women articulate sexuality and how the words we use describe our relations with structures of power. In this "post-gay" era of "increasing internal specification" within lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) communities (see Ghaziani 2011; Stein 2010), I was interested to explore how other bisexual and queer young women are making sense of identity politics and their role in gender, sexual citizenship, and health. Crucially, how might the ways we identify impact on our ability to access and experience health and wellbeing? These questions are compelling to consider in the rural Australian context where LGBTIQ young people continue to face structural barriers to healthcare that preclude our equal citizenship. In this thesis, I am interested in two key questions: How do Tasmanian queer young women understand and experience identity, health, and sexual citizenship in the context of neoliberal post-feminism? And what are the effects of these experiences on the health-seeking behaviours and sexual health outcomes of these young women?

To examine these questions, it is useful to first consider the cultural context in which women of this generation are coming of age. At the height of "raunch culture" and "hook up culture," millennial women (aged 18-30) are often positioned as "empowered" sexual citizens (Levy 2005). Contemporary (white, middle class) young women have grown up with understandings of gender, sexuality, and feminism filtered through the "girl power" rhetoric of the 1990s-

2000s, establishing an ethos where feminism is invoked only to show how it is no longer necessary (McRobbie 2009). Feminist scholars have described this as "post-feminism," referring both to a point in time, a backlash, and a generational shift beyond second wave feminisms of the mid-20th century (see Butler 2013; Faludi 1991; Genz 2006; Gill 2007; McRobbie 2009; Tasker and Negra 2007; Whelehan 2000, 2010; Wolf 1990). The post-feminist woman is "sexually subjectified" – she actively negotiates sex on equal footing with men and unapologetically articulates her desires (Gerhard 2005). She is sexually adventurous but takes responsibility for her sexual health. She is a 'good' sexual citizen.

However, Australian statistics tell a different story of sexual selfhood. Australian young women are not the empowered sexual subjects post-feminist media and culture portray them to be. Despite the ubiquity of "safe sex" messages in Australian public health campaigns since the 1980s, average rates of sexually transmissible infections (STIs) among young women in all states continue to rise (Australian Bureau of Statistics 2012a). Although the availability of sexual health information has increased, young women continue to exhibit low sexual health literacy and report that school-based sex education fails to adequately prepare them to negotiate safer sex (Equality Rights Alliance Young Women's Advisory Group 2016). While the "Tinder generation" may be having more casual sex than generations past, young women are now more likely than their predecessors to consent to unwanted or unsatisfactory sex and experience high rates of rape and sexual assault (Burkett and Hamilton 2012). In this context, this thesis questions how neoliberalism and post-feminism shape young women's understandings and approaches to sexuality and sexual health. What are young women's embodied experiences of negotiating safer sex? And what is the role of healthcare in post-feminist sexual citizenship?

While media representations position young (white, middle class, heterosexual) women as active sexual citizens and health consumers, there is little sociological analysis of how post-feminism and neoliberalism influence and reflect queer young women's lived experiences. For the most part, queer young women's

experiences are absent from narratives of post-feminist sexual citizenship. This is reflected in the dearth of sociological research around queer women's sexual health. Furthermore, because post-feminist theorising and queer sexual health research predominantly focus on urban populations, few sociological studies consider queer young women's sexual health politics in rural settings. To address these knowledge gaps, this thesis focuses, specifically, on bisexual and queer women because these experiences are rarely examined in isolation from lesbian experiences. As I will discuss in Chapter 2, the decision to focus on bisexual and queer young women was largely a result of participant self-selection, as curiously no lesbian-identifying young women chose to participate in the study despite inclusion criteria inviting any same-gender attracted young women to participate. However, as I will discuss in Chapters 1 and 3, bisexuality and other fluid expressions of sexual identity are increasingly common among young women, making the sample population of this study an intriguing microcosm of a potentially broader social pattern (see Callis 2014). As I shall discuss in detail in Chapter 2, I use the terms "bisexual and queer" to describe the participants largely following for their own self-labelling, and also drawing on deployments of "queer" as a broader signifier for non-heterosexual and plurisexual identities (Albury 2015). While I acknowledge the political debates around the term "queer" in Chapter 1, I use it in this way throughout this thesis out of respect for the participants' language to describe their experiences.

This thesis expands this area of inquiry by exploring how rural Australian bisexual and queer young women navigate identity, sex, and health. In particular, I consider how post-feminism influences queer rural young women's understandings of "good" sexual citizenship. Here, I refer to sexual citizenship as a series of rights, obligations, and subject positions that centre on gender, sex, sexuality and intimate life (see Evans 1993; Duggan 2002; Plummer 2003; Richardson 2015). Sexual citizenship highlights sexuality as an important aspect of identity and a form of civic engagement (Illes 2012: 616). Throughout this thesis I examine queer young women's civic engagement through their approaches to identity and health politics in a neoliberal, post-feminist cultural climate. In doing so, I shall show how queer sexual citizenship in contemporary

rural Australia has the potential to trouble dominant narratives of depoliticised queer youth and tell stories of resilience and resistance.

From 2015 to 2016 I conducted in-depth interviews with 15 young women from Tasmania, a rural Australian state. These women shared their experiences of identity building, negotiating sex, and accessing sexual healthcare. Drawing on these experiences, throughout this thesis, I examine queer post-feminist sexual citizenship in order to make sense of the complex ways queer young women navigate neoliberal post-feminism to create authentic sexual selves.

Background and Context

Over the last three decades, the intersecting rise of neoliberalism and post-feminism has shifted the ways in which gender, sexuality, and citizenship are framed socially, politically, and economically in the West. Feminist politics are increasingly repositioned as unnecessary or purely a matter of individual choice (see Gill 2007; McRobbie 2009; Whelehan 2010). At the same time, LGBTIQ identities are similarly becoming divorced from social movement politics and are increasingly situated in individualist consumer rhetoric of "homonormativity" and assimilation (see Duggan 2002, 2012; Ghaziani 2011). Just as we are "post"-feminism, scholars similarly assert that we are "post gay" – that sexuality is no longer a defining feature of our identities (see Adams et al. 2014; Archer 2004; Lea, de Witt and Reynolds 2015). Linking these developments is the neoliberal shift towards depoliticised individualism - where identities are separated from a critical discussion of inequality, social structures, and the redistribution of power. Despite neoliberal assumptions of a free market that drives meritocracy and equality, this paradoxically produces increased structural inequalities while limiting the state's responsibility for addressing them (Hale 2005).

These theoretical developments are frequently used to illustrate the growing phenomenon of young people rejecting traditional sexual identity labels in favour of more ambiguous subjectivities (see Adams et al. 2014; Callis 2014; Coleman-Fountain 2014; Hegna 2007). In a climate of increasing sexual and

gender diversity in the West, binary labels like "gay" or "lesbian" appear to be falling out of place with a new generation (Keating 2017), leaving many older members of the LGBTIQ community questioning the future of politics and activism based on shared sexual identities (see Riggs 2010). Are we experiencing a "shrinking of the lesbian world"? (Stein 2010). Does this new fluidity mark "the end of gay"? (Archer 2004).

In Australia, contemporary culture, politics, and current affairs suggest anything but. In 2014, a national survey found that the proportion of Australians who identify as LGBTIQ is increasing, especially among young people (Ray Morgan Research 2014). This is also reflected in most recent Australian census data, which recorded 47,000 same-gender couples in 2016, a 42 per cent increase since 2011 and an 81 per cent increase since 2006 (ABS 2017a). Similarly, LGBTIQ issues are now frequently centre stage in globalised western media and popular culture, from high-profile "coming out" stories of celebrities (e.g. Caitlyn Jenner, Ellen Page, Miley Cyrus) to growing queer representation in mainstream television and film (e.g. *Orange is the New Black*, *Transparent*, *Moonlight*). This increased queer visibility also comes at a time when LGBTIQ rights are becoming increasingly prominent in Australian political discourse. Over the last decade, national debates about marriage equality (see Karp 2017), the controversial LGBTIQ-inclusive Safe Schools Coalition (see Law 2017), changes to anti-discrimination legislation (Aird 2017), and transgender recognition (see Hall 2017; Sainty 2018), have all raised broader questions about the place of LGBTIQ people in Australian society, about ethics and morality, rights, and citizenship.

Despite significant gains for LGBTIQ communities, LGBTIQ Australians continue to experience systemic marginalisation, including higher rates of harassment, violence, and discrimination in many aspects of contemporary life (Australian Human Rights Commission [AHRC] 2015). LGBTIQ people have significantly poorer mental health and higher likelihoods of depression, self-harm, and suicide than their heterosexual peers (see AHRC 2015; Corboz et al. 2008; Leonard et al. 2012; Robinson et al. 2014). While LGBTIQ people share the full range of health risks with the rest of society, they also have specific health and

healthcare needs relating to chronic disease risk, mental health, intimate partner violence, gender identity, STIs, and Human Immunodeficiency Virus (HIV) (for an overview, see Fish 2006; Leonard et al. 2012; Rosenstreich et al. 2011; Zeeman et al. 2014). However, despite their poorer overall health and wellbeing, LGBTIQ health continues to be poorly understood and barriers to accessing LGBTIQ-inclusive medical care persist.

Following the HIV/AIDS epidemic, most sociological research on sexual health focuses on gay men (e.g. Flowers et al. 1999), young people (e.g. Hittner and Kryzanowski 2010), and heterosexual adults in urban areas of the UK and US (e.g. Moore and Halford 1999). Little is known about bisexual and queer women's health experiences, needs, and concerns, particularly in Australia (for important exceptions, see McNair 2009, 2015; Mooney-Somers et al. 2014; Power et al. 2009; Richters et al. 2010). Studies suggest that Australian queer women exhibit some of the lowest rates of preventative healthcare access among the LGBTIQ community, are much less likely to disclose their identity to healthcare providers, and report lower satisfaction with the care they receive (see Farmer et al. 2015; McNair 2009; Mooney-Somers et al. 2014; Mulligan and Heath 2007; Munson and Cook 2016; Power et al. 2009). Queer young women are more likely to experience coerced and unsafe sex with men at a younger age than their heterosexual peers (Dempsey et al. 2001; Hillier et al. 2010). Bisexual women are also more likely than lesbian and heterosexual women to combine sex with alcohol and illicit drug use, reducing their use of safer sexual practices (Grulich et al. 2003). This is particularly the case for queer young women in rural areas (Poon et al. 2009; Saewyc et al. 1999).

Australian sexual health research is predominantly situated in urban contexts, with most rural studies focusing on heterosexual youth (see Bishop 2013; Hillier et al. 1997; Senior et al. 2014). Similarly, while LGBTIQ health research is a growing field, the majority of this work has also been conducted in urban settings in the Global North. Within Australia, queer narratives of place position the major cities, Melbourne and Sydney, as "gay spaces," with the majority of Australian queer sociology and research located in these contexts. However,

studies indicate that geographic location is a key determinant of health that is further exacerbated for LGBTIQ young people in regional and rural areas (see Farmer et al. 2015).

Previous research suggests that rural queer women experience greater social isolation, lower self-assessed health status, reduced connectedness to LGBTIQ communities (which are common sites for health promotion), and poorer access to inclusive health services (see Farmer et al. 2015; Poon et al. 2009; Whitehead et al. 2016). However, there is a dearth of Australian qualitative studies providing in-depth data on rural queer women's lived experiences. This research uniquely contributes to Australian sociological literature by examining queer women's sexuality and sexual health in the rural island state of Tasmania.

Why study queer women in Tasmania?

Fig 1

Located 240 kilometres off the southeast coast of the Australian mainland, Tasmania is an isolated, largely rural island with a population of approximately 500,000 people (see Fig 1). Hobart is the capital city and most populous (pop. 200,000). Tasmania exhibits some of the nation's lowest average incomes, poorest educational levels, highest unemployment and welfare dependency, and some of the country's poorest health outcomes (ABS 2012b; 2014a). Tasmania

was the last Australian state to decriminalise homosexuality in 1997. Prior to this, Tasmania was known for having Australia's harshest penalties for cross-dressing and consensual sex acts between adult men. Efforts to repeal laws that criminalised homosexuality began in the 1970s, but came to a head in the late 1980s with the founding of the Tasmanian Gay and Lesbian Rights Group (TGLRG). With a view to raising awareness and dispelling myths about homosexuality, the TGLRG held a market stall in Hobart's popular Salamanca Market to collect signatures supporting decriminalisation. In 1988, the Hobart City Council banned the group from the market and, in what has been referred to as the largest act of queer civil disobedience in Australian history, the TGLRG defied the ban and continued to operate the stall. Over a series of weekends, 130 arrests were made.

Despite its troubling past, over the last two decades, Tasmania has led the way in Australian gay law reform, becoming the first state to officially recognise same-gender relationships and overseas marriages, to legalise same-gender parent adoption, and to introduce marriage equality legislation to parliament (Baird 2006). In 2008, the Hobart City Council apologised for its 1988 actions and acknowledged the prejudice it fostered against the LGBTIQ community. In 2017, the State Government expunged the criminal records of gay men arrested and charged for acts of "indecency" prior to 1997. Despite Tasmanians' support for decriminalisation being well below national average in 1988 (Carbery 2014; Marks 2013), contemporary polls consistently indicate support for LGBTIQ rights is now higher in Tasmania than nationally (see Croome 2013: 32). For example, in 2016, LGBTIQ Tasmanians expressed the nation's toughest opposition to the proposed marriage equality plebiscite, with Tasmanian LGBTIQ advocates warning that a plebiscite would reintroduce the harmful, anti-gay rhetoric reflective of the Tasmanian decriminalisation debates (see McIlroy 2016). Recently, in the 2017 marriage equality postal survey (which saw Australians vote in favour of legalising marriage between couples of the same gender), 63 per cent of Tasmanian respondents voted in support of marriage equality (ABS 2017a). However, support for LGBTIQ rights remains clustered around the major cities, with the state's rural areas exhibiting greater social and

religion conservatism and reduced access to inclusive services.

Tasmania's unique health profile and important LGBTIQ social history makes it a compelling site to study contemporary queer identity and health politics. In this thesis, I explore queer women's experiences in particular, because, despite the history of LGBTIQ activism and social reform in Tasmania, there are few accounts of women's roles in this story, nor how lesbian feminist activism has shaped life for subsequent generations of Tasmanian queer women. As a young queer Tasmanian, acknowledging this recent history is an important part of my identity, and shapes the way I feel connected to home. Considering the lack of recent social research on the subject, I wondered how other Tasmanian queer young women made sense of their identities. What is it like being young and queer in Tasmania today? What enables Tasmanian queer young women to thrive? What barriers are we yet to overcome?

Research Questions and Aims

Throughout this thesis, I argue that the impact of neoliberalism on sexual citizenship warrants further consideration in the Australian context, and that queer young women's experiences provide important insight into the intersection of post-feminist and post-gay discourses. While the majority of post-feminist and post-gay theorising has occurred in "gay spaces" that have undergone urban gentrification (see Holt 2011; Lea, de Witt and Reynolds 2015; Reynolds 2009), Tasmania is a unique case study because, despite developments towards equality, queer visibility continues to be low in the isolated, rural context, producing continuing barriers for young women. Therefore, the aim of this research is ultimately to examine how neoliberalism, post-feminism, and homonormativity inflect queer young women's identity politics and sexual citizenship in rural Australia. My hope is that this will provide new insight for sociological perspectives on neoliberalism, identity, health and rurality.

Empirically, this research aims to address the dearth of qualitative sociological research on queer young women's understandings and experiences of sexuality

and sexual health in regional and rural Australia. In doing so, this thesis also aims to inform and improve social supports, public policy, education, and medical practice specific to LGBTIQ young people in Tasmania and other rural areas elsewhere.

To achieve these aims, this thesis addresses the following research questions:

1) How do Tasmanian queer young women conceptualise, negotiate, and experience identity, health, and sexual citizenship in the context of neoliberal post-feminism?

2) How does heteronormativity impact Tasmanian queer young women's experiences of "safe sex" and sexual health?

3) What are the effects of these experiences on the health-seeking behaviours and sexual health outcomes of Tasmanian queer young women?

4) How do healthcare providers accommodate these experiences through inclusive practice?

Theoretical Framework

Intersectional feminist and queer theoretical frameworks inform this thesis. Intersectional perspectives pay attention to the ways in which the multiple subject positions individuals occupy (e.g. gender, sexuality, race/ethnicity, class) carry differing levels of privilege and (dis)advantage that intersect in complex ways (for an overview, see Crenshaw 1989, 1991; Hill Collins 1998; hooks 1984; Lorde 1984; Yuval-Davis 1997). For feminists, intersectionality "demonstrates a consensus that homogenising, essentialist, and exclusionary models of identity that falsely universalise relatively privileged experiences and identities to all 'women,' marginalise some women while centring others" (Carastathis 2016: 2). While some scholars argue that intersectionality is under-theorised in queer theory (see Cohen 1997), others have documented the parallels (see Taylor et al.

2010). Critical queer perspectives challenge and deconstruct the taken-for-granted normative assumptions about daily life and draw attention to the discursive construction of identities. Together, these approaches provide a framework for critiquing the multi-layered systems of power, privilege, and oppression that are intentionally obscured under neoliberalism. Intersectional feminism and queer theory are therefore helpful for exploring issues such as identity politics and health because they aim to show how social divisions interconnect, structurally and subjectively.

Intersectional feminism and queer theory present a challenge to neoliberal ideas about identity and responsibility that are increasingly widespread in healthcare. Such theories highlight the importance of language, discourse, identity, and power in health and offer a way to critique neoliberal ideologies. These theories also provide a way to challenge the individualism and assumed "neutrality" of neoliberal citizenship by paying attention to positions of privilege (e.g. whiteness, heteronormativity) that are rarely explored in depth. Key to both intersectionality and queer theory are concepts of difference, power, and identification. Such concepts are central to understanding queer health politics and therefore provide useful structure for this analysis.

Jose Esteban Muñoz (1999), for example, argues that individuals are constituted through their identifications with others. However, for Muñoz (1999: 5), this is a contingent process, with identities being fragmented, multiple, intersecting, and constantly in flux. Therefore, subjects can partially identify and counter-identify with certain identities especially when "hailed by more than one minority identity component" (Muñoz 1999: 12). Muñoz (1999: 11) describes "disidentification" as a "transformative political strategy that works both with and against ideological interpellation" (Raby 2005: 165). Muñoz's "disidentification" is a useful concept to theorise individuals' reflexive identity construction in post-modernity (see Beck 1992; Giddens 1991) and demonstrates how minority subjects can inhabit multiple conflicting identities in different contexts. Muñoz (1999: 11) argues that minority subjects "disidentify" with certain positions as a "survival strategy" in oppressive systems – engaging

in reflexive identity work to avoid stigma.

In this thesis, I use the concept of disidentification to provide an alternative reading of post-feminist and post-gay identity politics and healthcare for queer young women in rural Australia. In doing so, this thesis makes a novel contribution by bringing the under-utilised theoretical perspective of Muñoz to Australian feminist health sociology. My use of Muñoz's work in this thesis presents a new way to engage with queer identity politics in Australian health settings. Drawing on Muñoz, throughout this thesis I shall show how this particular group of white, middle-class, millennial queer women's reflexive identity politics and their navigation of sexual healthcare all point to a new mode of queer sexual citizenship. Therefore, this research offers a unique theoretical tool with which to re-examine, interrogate, and re-imagine queerness, identity, and health politics under neoliberalism.

Overview

Chapter 1 critically reviews the literature on queer women's sexual health and outlines the conceptual framework underpinning this thesis. I map the theoretical and socio-historical developments of neoliberalism and post-feminism to show how these contextualise contemporary framings of young women's sexualities. I argue that queer young women's experiences have a role in potential shifts beyond post-feminism and I deploy Muñoz's (1999) "disidentification" to demonstrate how nuanced negotiations of identity can challenge post-feminism's neoliberal individualism. Here, I will explain queer theory and intersectionality to provide a theoretical context for the use of disidentification in this thesis. Chapter 1 also provides an overview of current empirical research on queer women's sexual health, identifying the gaps this project aims to address.

Chapter 2 describes the methodological approach to this research. I describe the procedures involved in the conduct of this research, including qualitative interviewing and grounded theory analysis. In the tradition of feminist research,

I reflexively consider my standpoint as the researcher and author of this thesis. I share my own negotiations of identity as a queer researcher and the power differentials involved in interviewing other queer young women and medical professionals. I also reflect on research design (e.g. the use of self-selected recruitment methods and in-depth interviewing). I discuss important ethical and methodological considerations including negotiating language, identity, and naming in LGBTIQ research.

Chapter 3 develops this central theme of articulating queer identities. I explore how participants understand and claim identity. I argue that the young women are critical of sexual identity labels, and instead engage with a neoliberal politics of normalisation to position themselves as "ordinary," "unremarkable" queers. While this can be read as a demonstration of privilege and homonormativity, I draw on Muñoz's (1999) "disidentifications" to illustrate how these rejections of traditional identity labels are nuanced. Here, I argue that the women simultaneously invoke post-feminist neoliberalism while subverting it through their experiences of queerness. This is a central theme of this thesis.

Understanding how queer women construct and articulate identities is important for more inclusive and equitable health service provision. Chapter 4 examines how women understand and experience sexuality and sexual health, starting with sex and relationships education (SRE) in school. Here, despite initially claiming ordinariness, participants outline experiences of marginalisation and erasure as queer women, for whom school-based sex education is remembered as heteronormative, biomedical, and risk-based. In light of this, I argue that participants' disidentifications act as a defense mechanism in order to avoid further marginalisation in heterosexist systems. This is especially evident in terms of how they approach sexual health literacy and healthcare access.

Chapter 5 builds on the findings of Chapter 4 by arguing that the neoliberal, health focus of participants' sex education reproduces a post-feminist responsibilising discourse that has not adequately prepared them for navigating

the gendered power dynamics involved in practicing safe sex. Heteronormative sexual scripts also shape participants' understandings and negotiations of safer sex with women. Here, it is participants' experience of queerness that problematises their attempts to portray themselves as "good" post-feminist sexual citizens and health consumers. I argue that this further demonstrates participants' disidentifications, as the women simultaneously incorporate and reject dominant structures of identity, sex, and health.

The themes of the thesis converge in Chapter 6, which examines women's experiences of accessing sexual healthcare and negotiating inclusivity with Tasmanian healthcare providers. First, I contextualise participants' healthcare experiences with an overview of Australian LGBTIQ-inclusive practice guidelines and policies (e.g. the Gay and Lesbian Health Victoria (2013) inclusive practice model, the Royal Australian College of General Practitioners' Curriculum (2016)). Next, I evaluate the healthcare participants have received, comparing and contrasting these experiences with accounts from general practitioners in Tasmania. I argue that while neoliberalism inspires a proliferation of individualised and increasingly specific queer sub-identities, it paradoxically constricts these identities when it comes to accessing institutions and services. Therefore, although participants initially portray themselves as ordinary citizens, the discrimination and structural barriers they face in accessing equitable and inclusive sexual healthcare demonstrates how vital identities are for mobilising for collective rights and recognition. Therefore, I argue that disidentification works as a survival strategy for queer young women. Claiming "ordinariness" is a necessary response to gain access to health services that are already limited in parts of rural Tasmania.

This thesis addresses key knowledge gaps in the existing literature by providing timely insight into the lives of bisexual and queer young women in Tasmania, Australia. I argue that post-feminist and post-gay discourses are underpinned by a privileged, white, urban, neoliberal subject. The effect of this is marginalisation of rural queer women's experiences. It also fails to account for the continued structural barriers queer women face in terms of broader visibility and

acceptance. However, I also consider how participants situate their gender, sexuality, and health politics as white, middle class queers, demonstrating how these politics are inflected by complex, neoliberal power structures. Therefore, this thesis critically engages intersectional queer theoretical perspectives to argue that collective identity politics are still necessary to combat the inevitable depoliticisation that a neoliberal "post-identity politics identity politics" brings (see Riggs 2010).

Chapter 1: Literature Review

Introduction

This chapter situates the thesis with existing gender, sexuality, and sexual health scholarship in neoliberal post-modernity. Here, I outline the theoretical context of this research and map what is currently known about queer women's experiences of sexuality and sexual health. In doing so, I identify the gaps in knowledge and discourse that this research addresses. I begin with a discussion of sexuality and gender in post-modernity, exploring the theoretical and social origins of neoliberalism, post-feminism, queer theory, and intersectionality. The second part of this chapter reviews empirical work around queer women's sexual health, their experiences with health systems, and LGBTIQ-inclusive medical practice. This research contributes to this body of work by using an intersectional feminist lens to provide deeper insight into queer young women's lived experiences of sexual health in rural settings.

Theoretical Framework

Theorising Sexual Citizenship: Neoliberalism and Post-feminism

An examination of neoliberalism provides a deeper understanding of both the political, socio-historical, and theoretical contexts in which post-feminist, queer, and post-gay discourses can be situated. While much of the theorising on neoliberalism situates it as a political theory based on free market economics (see Bell 1997; Harvey 2005), other scholars argue that neoliberalism has much broader social implications (see Brown 2005; Chen 2013; Duggan 2012; Hay 2000). Drawing on Foucault's concepts of governmentality and biopolitics, Rose (1999) and others (see Connell 2002; Chen 2013; Duggan 2012; Hay 2000; McRobbie 2009) demonstrate how, under neoliberalism, citizen-subjects are positioned as self-governing individuals who are responsible for their own

individual choices, while state responsibility for social provision is withdrawn and "basic biological features of the human species become the object of political strategy" (Foucault 1980: 1). Accordingly, neoliberalism favours privatisation of state-owned enterprises and reduction of government regulation to prioritise individual freedom and choice (Chen 2013: 441).

Some sociologists argue that by destabilising traditional social order, neoliberalism has positively impacted society by allowing more opportunities for individual agency and choice (see Beck 1992; Giddens 1991). Here, the significance of structural factors such as gender, sexuality, race, and class are de-emphasised, as individuals are "free" to cultivate their own identities on the basis of personal choice. Beck and Beck-Gernsheim (1995: 5) refer to this as the post-modern "Choice Biography." However, feminist scholars have argued that a conservative reinstatement of gender, sexuality, class, and racial hierarchies is often implicit in neoliberal discourse (e.g. Butler 2013: 41; Duggan 2002; Mulinari and Sandell 2009). Thus, while neoliberalism promotes individual rights, it problematically divorces those rights from the redistribution of power and resources, causing greater social inequalities while dissolving any collective ability to criticise or address these (Hale 2005: 12-13).

The concept of neoliberalism is widely applicable in a range of contexts, disciplines, and forms of critique. However, this theoretical flexibility has drawn criticism from multi-disciplinary scholars who claim that neoliberalism is now overused but under-theorised (see Birch 2015; Davis 2008; Ganti 2014). For instance, Bell and Green (2016: 241) argue that neoliberalism has become a totalising and monolithic concept that is seldom explicitly defined in sociological analysis. Davies (2014) similarly proposes that "neoliberalism is often unmoored from its complex historicity and used indiscriminately and pejoratively to signal anti-democratic and anti-corporate power" (Grzanka et al. 2016: 297). Following these criticisms, some argue for the abandonment of neoliberalism as a meaningful concept in social theory (Boas and Gans-Morse 2009; Monboit 2016). However, as Grzanka et al. (2016: 299) suggest, the ongoing significance of neoliberalism in economic policy, social policy, and global cultures warrants

greater theoretical and empirical specificity.

In light of debates that call for a more nuanced deployment of neoliberalism, throughout this thesis I consider how particular aspects of neoliberal ideologies shape gender, sexuality, and sexual health in Australia. In the tradition of sexuality and queer scholarship, my theoretical approach to neoliberalism is influenced by a Foucauldian framing (e.g. Rose 1999), rather than the strictly economic Marxist approach (e.g. Harvey 2005). Therefore, in this thesis, I define neoliberalism as the constellation of practices by which the state influences and evaluates individuals' behaviours through self-discipline and surveillance (Grzanka et al. 2016: 298). I also draw influence from Puri's (2016: 308) definition of neoliberalism as a hegemonic ideology. However, as Puri (2016: 309) importantly elaborates, the relationship between neoliberalism and sexuality is not necessarily linear, but "co-constitutive" - meaning that just as neoliberal policies produce certain sexualities, sexual cultures can also intervene in neoliberalism.

Neoliberalism has been referred to as "shorthand for an array of complex economic, political, and cultural dynamics" (Grzanka et al. 2016: 300), with some theoretical overlap with sociological perspectives like Giddens' (1991) "late modernity" and Beck's (1992) "risk society." However, I focus on neoliberalism in this thesis (rather than "late modernity," for example) because of its intersections with post-feminism (see Gill 2007; McRobbie 2009) and contemporary critiques of queerness.

Over the last two decades, scholars from a range of fields have considered how neoliberalism is inflected through notions of sexual citizenship (see Brown 2012; Duggan 2002; Evans 1993; Phelan 2001; Richardson 2005; Weeks 1998). Citizenship can be defined as "the political and social recognition that is granted to those whose behaviour accords with the moral values underpinning the construction of the nation state" (Hubbard 2001: 53). Citizenship discourse was initially constructed around civil, political, and social components of citizenship (see Marshall 1950 cited in Cohen 2010; Turner 1993), however more recent

theorising has turned its attention to the ways in which citizenship is gendered, racialised, and sexualised (Robson and Kessler 2007: 583). For Johnson (2017: 160) the concept of sexual citizenship "draws on work which emphasises the social and political significance of intimate life, including issues regarding gender, identity, relationships, family, the body and emotional life." Therefore, sexuality can be understood as central to the notion of citizenship, as our "intimate lives" (Plummer 2003: 13-16) are often at the core of national political and cultural agendas (Cossman 2007; Duggan 2003; Evans 1993; Hubbard 2001). Dominant cultures determine a certain set of relationships and behaviours as constituting "good" sexual citizenship, with sexual "others" being denied full citizenship in terms of state benefits and political recognition (Bell and Binnie 2000; Duggan 2003; Pateman 1989; Rubin 1999). For instance, drawing on feminist understandings of gendered citizenship, sexual citizenship scholars argue that citizenship rights are constructed in a way that assumes heterosexuality (Bell and Binnie 2000; Johnson 2017; Puar 2007).

Sexual citizenship is implicated in how citizenship is conceived more broadly and in particular forms of individual governance (Johnson 2017: 161). Neoliberal forms of sexual citizenship position sex and sexuality as individual rights and responsibilities (Butler 2013: 41). In her influential work, Lisa Duggan (2002) argues that neoliberalism inflects contemporary LGBTIQ rights agendas by shifting the focus from politicised collective identity-based action to calls for assimilation and individualised rights and freedoms (see also Ghaziani 2011; Richardson 2005). In what has been referred to as the "post-gay" shift, scholars argue that neoliberal ideologies implore individuals to move away from politicised collective identities and to instead construct their own highly specific, but depoliticised and private, sexual and gender identities (see Adams et al. 2014; Coleman-Fountain 2014; Halberstam 2005; Hegna 2007; Stein 2010). Duggan (2002: 179) describes this shift as the "new homonormativity," a paradigm where privileged "mainstream" (white, urban, middle-class, cisgender, monogamous) gay men and lesbians are "ordinary, normal citizens" who "do not contest dominant heteronormative assumptions and institutions, but uphold them while promising the possibility of a demobilised gay constituency and a

privatised, depoliticised gay culture anchored in domesticity and consumption." These trends demonstrate that neoliberalism is more than just an economic theory, but an ideology that profoundly shapes even the most intimate aspects of our lives.

However, despite neoliberalism's focus on a "neutral" citizen, notions of sexual risk and responsibility are profoundly gendered. In neoliberal post-modernity, where individuals have become "disembedded" from traditional social structures and life-courses, feminist scholars have argued that young women are under particular pressure to reflexively negotiate shifting norms, roles, and risks by making the "right" sexual choices (Butler 2013; Beck and Beck-Gernsheim 1995; McRobbie 2009, 2011; Mulinary and Sandel 2009). It is within this complex socio-political environment of neoliberalism that post-feminism has emerged as a contemporary ideology of gender, sexuality, and sexual citizenship.

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It is within this complex socio-political environment of neoliberalism that post-feminism emerges as a contemporary ideology of gender, sexuality, and sexual citizenship. Post-feminism is a complex and contested concept, with multiple, well-rehearsed interpretations. Developing out of the fractures caused by the 1980s feminist "sex wars" (for an overview see Whelehan 1995: 126), post-feminist discourse can be seen as an "aftermath" of the achievements gained from second wave feminist movements throughout the West in the late 1960s and early 1970s. Although the "post" prefix in post-feminism has been seen to represent the notion that second wave feminism is "dead," it also can be understood as "an emerging culture and ideology that simultaneously incorporates, revises, and de-politicises many of the fundamental issues advanced by feminism" (Rosenfelt and Stacey 1990: 549). Some scholars also argue that the "post" prefix might symbolise a more positive association, an "in relation to" rather than a "split from" earlier feminisms (Nash and Grant 2015). For Gill (2008: 442) post-feminism can be understood as a "sensibility" that distances itself from both feminist and anti-feminist constructions of gender,

while actively responding to both. Gill's (2007: 147) post-feminist sensibility involves an intersection of individualism and choice, feminine bodily control, and a shift from sexual objectification to "subjectification". Post-feminism is thus positioned as part of a contemporary neoliberal refashioning of femininity in which women escape traditional boundaries of femininity through a continual reworking of subjectivity as subjects and objects of commodification and consumerism.

In keeping with the neoliberal, reflexive post-modern self, the post-feminist sexual citizen is established as (hetero)sexually knowing and desiring in the process of her own objectification – she is always "up for it" (Gill 2009; Whelehan 2000). Despite deploying the feminist sentiment of empowerment, post-feminist culture calls for women to experience choice and liberation through cultivating the stereotypically "sexy" body (Gill 2007; Ringrose et al. 2013). Through this process, any decisions women make are depoliticised as "lifestyle choices," ignoring the structural influences shaping the contexts in which women act (Gill 2007). This post-feminist subject is "a sexually savvy and active woman who can participate appropriately in consumer practices and in the production of her choice biography" (Evans et al. 2010: 115). However, Levy (2005: 198-200) argues that post-feminist raunch culture is less about erotic freedom for women and more about consumption and internalisation of "caricatures of female hotness" that restrict what it means to be "sexy" within a male-defined, heteronormative schema.

While these constructions of post-feminist sexuality may have some significance in their recognition of women's agency, they fail to meaningfully engage with structural determinants of gender inequality, whiteness, and institutionalised heterosexuality. Therefore, although post-feminism has a strong hand in shaping young women's lives, it nevertheless fails to meaningfully accommodate experiences of queerness. To frame how young women navigate and claim queerness, in the following section I examine the theoretical development of queer theory.

Theorising Sex and Identity: Queer Theory, Intersectionality, and Disidentification

An exhaustive review of the development of queer theory is beyond the scope of this chapter and is undertaken elsewhere (see Jagose 1996). However, in this section I will briefly outline some of the key concepts in order to contextualise contemporary understandings of queer identity politics discussed in later chapters.

Queer theoretical approaches are critical of the notion of an essential or innate gendered, sexual self. Instead, queer theorists draw from constructionist traditions to argue that gender, sexuality, and identity are created and reproduced through social interaction and performance (see Butler 1990, 1991; De Lauretis 1990; Fuss 1991; Sedgwick 1990; Weeks 2003; West and Zimmerman 1987). These approaches stem from the early works of Kinsey (1948, 1953) and McIntosh (1968), who pioneered the notion of sexuality as a socially produced spectrum, rather than a "natural" binary. For example, Sedgwick (1990) questions the dichotomous nature of identity established through the contemporary "coming out" meta-narrative of being in or out of the closet (see also Fuss 1991; Plummer 1995). Like Foucault (1979), Sedgwick (1990) and others (e.g. Esterberg 1996; Halperin 1990; Ingraham 1996; Jackson 2003; Weeks 2003) challenge structuralist notions of sexuality as constituting an inner truth to the self that, when revealed through the narrative process of "coming out," will bring renewed meaning to one's identity. From these perspectives, the process of coming out is less of a realisation of essential truth than a process of identity construction and a narrative ordering of subjective reality (see Plummer 1995; Weeks 2003). Therefore, queer theory intentionally destabilises identity categories (see Butler 1991).

Queer perspectives on sexuality and identity have drawn the most sustained critiques. The emergence of queer theory intersected with critical debates in gay and lesbian communities around identity, naming, and group membership. Scholars and activists questioned: "if gay (and man) and lesbian (and woman) are unstable categories, what happens to sexuality-based politics?" (Gamson

1995: 399; see also Alcoff 1988; Hekman 2004; Malinowitz 1996). Butler (1991: 15) provocatively illustrates these concerns:

> What, if anything, can lesbians be said to share? […] What or who is it that is 'out,' made manifest and fully disclosed, when and if I reveal myself as a lesbian? What is it that is now known? Anything?

Bersani (1995) argues that the use of "queer" as an umbrella term for a range of non-normative sexualities and genders has a "de-gaying" effect, or a "liberal pluralism notorious for its capacity for co-option and depoliticisation" (Jagose 1996: 112). In response, Butler (1990: 148) argues that "the deconstruction of identity is not the deconstruction of politics, rather it establishes as political the very terms through which identity is articulated."

Queer is, therefore, problematic for gay and lesbian scholars whose academic and activist work fits into the "ethnic model" of identity, which strategically deploys essentialism to advocate for LGBTIQ people on the grounds of innate, shared identities (see Epstein 1998; Seidman 1997). Positioning LGBTIQ communities in a similar manner to ethnic minority groups has been instrumental in the campaigning for and achievement of rights for sexual minorities (Jagose 1996: 22). In light of the gains achieved by LGBTIQ activism under the ethnic model, some scholars are understandably sceptical of the seemingly nihilist deconstructionism of queer theory. If gender and sexual identities are arbitrary social constructs, how can we collectively mobilise against shared oppressions? Grosz (1995: 249-250) takes issue with the ambiguity of queer as a political category, arguing that its lack of clear constituency or definition makes it an impractical concept. Furthermore, by taking a radical, deconstructionist stance, some argue that the queer position is too politically naïve and idealistic to achieve any tangible social change (Watney 1992: 18).

Lesbian feminists argue that homogenising all non-heterosexual experiences under the convenient catchall of "queer" depoliticises and erases lesbians'

gender-specific experiences of heterosexist oppression (see Bonwick 1993; Castle 1993; Grosz 1995; Jeffreys 1994; Malinowitz 1996; Parnaby 1993; Wolfe and Penelope 1993). For example, Bonwick (1993: 10) argues that "the most damaging aspect of the pervasive push to be queer is that it shrouds lesbians in an even thicker cloak of invisibility. Queer totally ignores the politics of gender. Using a generic term wipes women out again." Similarly for Stein (2010: 25), queer poses a threat to lesbian collective identity in "the blurring of boundaries and the loss of a sense of what sets the group apart from others." Lesbian feminists are deeply critical of the way queer theory engages with gender, some arguing that it merely reproduces patriarchal structures rather than challenging them (Castle 1993; Parnaby 1993). However, although scholars like Jeffreys (1994) and Castle (1993) claim that queer theory is at odds with feminism, Jagose (1996: 119) points out that all the most prominent queer theorists draw heavily on feminist concepts and theory in their work.

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An important critique is that most of the work that has been canonised in queer theory is produced by white thinkers in the Global North. Smyth (1992: 35) expresses such reservations, arguing that:

> While queer raises the possibility of dealing with complex subjectivities and differences in terms of gender, race, and class, it also risks not trying hard enough to resist the reductive prescriptiveness some of us suffered in feminism and the uncritical essentialism that privileges the queerness of gay white men.

Subsequently, the work of black, chicana, indigenous, and third world feminists is often overlooked, despite its significance to feminist and queer theory. Queer women of colour have produced germinal texts that enable a more nuanced understanding of identity politics. For example, in her 1997 essay, 'Punks, Bulldaggers, and Welfare Queens: The Radical Potential of Queer Politics?', Cathy Cohen argues that the whiteness of queer theory and politics limits its radical

potential. The race and class privilege implicit in queer's fluidity causes it to reproduce heteropatriachal, white supremacist power structures (see Puar 2007). Here, Cohen (1997: 457) calls for a queer politics and theory that critically examines power dynamics within and outside queer communities, and not merely reproducing dichotomies between heterosexual dominance and queer oppression. In other words, Cohen advocates for an intersectional approach. This work importantly raises issues of intra-group differences that had not been addressed by white feminists and queer theorists, challenging notions of universal experiences of oppressions among women and queers.

Carastathis (2016: 2) explains that "an enduring obstacle to forming effective movements against oppressions is the fragmentation of identities and the divisions within and among communities of struggle." This is reflected in LGBTIQ identity politics debates between proponents of the ethnic model and queer (de)constructionism. As in feminist debates, intersectionality is deployed as a counter to the pitfalls of identity politics (see Alcoff 1988; Hekman 2004; Phelan 2003). Intersectionality derives from critical race studies in the context of feminist and queer identity politics that focus on the intersections of race, gender, class, and sexuality (see Crenshaw 1989, 1991; Hill Collins 1998; hooks 1984; Lorde 1984; Yuval-Davis 1997). Black feminist legal scholar, Kimberle Crenshaw (1989) originally coined the term to describe the "multidimensionality" of black women's experiences. This approach counters fragmentary identity politics by challenging the often-dichotomous nature of its debates, instead positioning identities as intentionally heterogeneous, complex entities.

However, as Carastathis (2016) points out, intersectionality is now mainstreamed in feminist academia and politics in a way that often appropriates the work of feminists of colour in white contexts, with little theoretical nuance. Some feminist scholars are therefore critical of the concept of intersectionality. For instance, Puar (2007: 212) refers to intersectionality as "a tool of diversity management and a mantra of liberal multiculturalism." Hornschied (2009) argues that intersectionality dominates feminist thought at the expense of other

perspectives, including early black feminist writing. Others argue that intersectionality over-emphasises identity categories rather than examining the dynamic processes and forces of power (see Choo and Ferree 2010; Hornschied 2009; Lutz et al. 2011). As Nash outlines (2008: 11-13), merely recognising the multidimensionality of identity is not enough to solve some of the problems with identity politics, with intersectionality leaving us asking "so what?" Puar (2007: 212) also illustrates this criticism, arguing that in mainstream approaches to intersectionality "'difference' is encased within a structural container that simply wishes the messiness of identity into a formulaic grid." In line with Puar, some feminists are concerned that intersectionality assumes subject positions such as gender, race, and class all function according to the same logic, failing to recognise the distinctive nature of each inequality strand (Squires 2007).

One exemplary deployment of a queer intersectional approach is found in the work of US cultural theorist, Jose Esteban Muñoz. In his 1999 book, *Disidentifications: Queers of Colour and the Performance of Politics*, Muñoz examines the ways queer people of colour are excluded from the white homonormativity of queer politics and theory. In Muñoz's work, "identification is not always smooth, but rather identities are fragmented, multiple, intersecting, and constantly in flux" (Raby 2005: 165). Therefore, Muñoz (1999: 12) argues that subjects can partially identify and counter-identify with multiple subject positions, as we are embedded in discourses but at the same time are constantly working "on, with, and against" cultural forms. Muñoz challenges the totalising explanations of identities as either essentialist or socially constructed, theorising that the realities of identity formation vary among individuals (1999: 5-6). This perspective encourages us to rethink the dichotomy between the minoritising ethnic model and queer post-structuralism, invoking intersectionality to explain identities as hybrid projects.

To theorise queer identity, Muñoz (1999: 11) draws on French Marxist philosopher, Michel Pecheux's model of identity construction: 1) Identification (the good subject), 2) Counter-identification (the bad subject), and 3) Disidentification,. Considering the "identities-in-difference" of queer people of

colour, Muñoz (1999: 7) demonstrates how new subject positions are formed out of disidentification with dominant structures of identity. For Medina (2003: 663-664), disidentification aptly captures the "structural messiness" of the "interlocking networks of similarities and differences that sustain identity." Drawing on Muñoz, Medina (2003: 660) uses the analogy of the family to illustrate how identity categories are unstable and internally heterogeneous. Like family structures, identity categories are approximate groupings of people with some shared characteristics, but also individual differences. In Medina's (2003: 663) analogy, disidentification occurs when individuals are made aware of internal differences in families and feel "ill at ease with members of their families." Butler (1993: 219) similarly describes disidentification as an "experience of misrecognition, this uneasy sense of standing under a sign to which one does and does not belong."

Muñoz (4) describes disidentification as self-creation, or a "survival strategy" for minority subjects who require a reflexive way of navigating the oppressive public sphere. One way for minority subjects to articulate complex, intersecting identities and oppressions is to redeploy dominant images, stereotypes, and language in disruptive ways – some common examples being the "reappropriation" of terms like "queer" or engaging in drag (Raby 2005: 154; see also Butler 1993: 219). For Butler (1993: 218), disidentification is useful for queer theory because it contributes to a destabilisation of the signifiers of identity and prompts "resignification" or "rearticulation" (Medina 2003: 664). In this way, disidentification reflects Robinson's (2013) concept of "strategic identities" or Riggs' (2010) "post identity politics identity politics." It is a purposeful and reflexive (re)engagement with and rejection of certain identities in certain contexts often for deeply personal and political reasons (see also Albury 2015).

As I will discuss in Chapter 3, Muñoz's (1999) work is important for this thesis as it provides a useful framework to explain the process of disidentifying with certain sexual identity labels. I am drawn to disidentification because of its nuanced balancing of essentialism and assimilation with constructionism and

radical queerness. However, the theoretical, political, and ethical implications of making use of Muñoz's theory in the context of this project are not lost on me. Considering Carastathis' (2016) critique of white appropriation of intersectionality as a feminist "buzzword," I acknowledge that the use of Muñoz's disidentifications in research focusing on white Australian queer women, conducted by a white woman, is potentially problematic. Indeed, Muñoz's concepts have very seldom been applied beyond the context in which they were originally theorised, being used predominantly in works engaging with critical race studies, borderlands theory, and studies of queer people of colour in the US (see Pérez 2003; Yon-Leau and Muñoz-Laboy 2010; for exceptions see Dean 2008; Medina 2003; Raby 2005). However, in light of Muñoz's (11) own critical observation that white feminist and queer scholars have often fetishised the works of women and queers of colour yet seldom engaged with them critically, I argue that deploying disidentification theory in this project facilitates this critical engagement with Muñoz's work in the global context.

Situating Queer Women in International Sexual Health Research

Having mapped the theoretical framework underpinning this thesis, in this section, I review the existing empirical scholarship on lesbian, bisexual and queer women's sexual health. This research began with a realisation that queer young women's experiences of safe sex and sexual health are invisible in Australian public health promotion and research. In addition to being incomprehensible in post-feminist models of sexual citizenship, there is a dearth of social research on queer women's sexual health, with the majority of sexual health research focusing on heterosexuals or gay men. Notwithstanding the growth of mainstreamed LGBTIQ-inclusive practice in healthcare, practitioners continue to lack knowledge, skills, and awareness of queer women's specific sexual healthcare needs.

Definitions of "safe sex" and sexual health are socially constructed and internationally contested. For instance, the World Health Organisation (WHO) (2006) defines sexual health as:

> A state of physical, emotional, mental, and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

This definition is important in its emphasis on individuals' rights to equality, respect, freedoms from discrimination and violence and access to relevant and correct sexual knowledge and information. Recognising and accounting for the social determinants of sexual health is useful for feminist sexual health research as it identifies that sexual health is critically influenced by gender norms, roles, expectations and power dynamics (see Amaro 1995). But despite WHO's holistic stance, in global public health discourse "safe sex" is often positioned as a biomedical concept, with dominant definitions centring on the prevention of infection and unplanned pregnancy through the use of barriers during (hetero)sex. Furthermore, Rosenstreich et al. (2011: 302) observe that the WHO made no references to diverse sexualities in its Commission on Social Determinants of Health in 2008. For Rosenstreich et al. (2011), this fails to take into account the continuing widespread discrimination faced by LGBTIQ people internationally, including violence, severe legal sanctions, and even the death penalty in some countries. Ample research indicates that experiences of discrimination contribute to poor health outcomes for LGBTIQ people, some of which I will explore in this section (see Pitts et al. 2009; Riskind et al. 2014; Rosenstreich et al. 2011).

As Rosenstreich et al.'s (2011) critique of the WHO definition implies, concepts of "risky" or "safe" sex, and those who engage in these practices are shaped by medicalised, heteronormative definitions and practices (see Cox and McNair 2009; Power et al. 2009; Richters et al. 2010). Subsequently, there is a dearth of research examining how queer women understand and practice safer sex. Safer sex discourse is now central in sexual health promotion campaigns seeking to circumvent rising rates of STIs globally. In this context, prioritising safe sex is

increasingly positioned as part of "good" sexual citizenship, especially for young women in a post-feminist climate (see Burkett and Hamilton 2012; Harris and Dobson 2015). However, British feminist health sociologist Diane Richardson (2000: 44) argues that STI risk perception and prevention among lesbians has been shaped by a socially constructed notion of immunity (see also Dolan and Davis 2003). For Richardson (2000: 33) predominant risk discourses during the HIV/AIDS crisis wrongly positioned lesbians among those least at risk of infection, with the "typical" women at risk being sex workers, women of colour, injecting drug users and those labelled "promiscuous" (see also Cox and McNair 2009; Richters et al. 2010). A number of assumptions underpin this construction of lesbians as "low risk", primarily, that lesbians never have sex with men and that the sex they have with women is "not real sex" (see Cox and McNair 2009: 16; Logie 2014: 7).

Despite this social construction of lesbian sexual health immunity (Dolan and Davis 2003), lesbian, bisexual and queer women do face numerous specific health concerns that are often overlooked in mainstream safer sex discourse. For example, although global rates of HIV transmission between women are low, women who have sex exclusively with women are still at risk of contracting a range of STIs, such as HPV (Ferris et al. 1996), Herpes (Marrazzo and Stine 2003), and Bacterial Vaginosis (Bailey et al. 2004; Marrazzo et al. 2005). Queer women are likely to have had unprotected sex with men, including gay and bisexual men, resulting in a similar prevalence of STIs among lesbian and heterosexual women, and possibly higher among bisexual and queer women (see McNair 2009; Mercer et al. 2007; Mooney-Somers et al. 2017: 24-25). Furthermore, queer young women report high rates of unwanted or coerced sex with men and intimate partner violence with partners of both genders (see McNair 2009; Mooney-Somers et al. 2017: 48). Thus, assumptions of lesbian sexual health immunity contribute to misinformation from health care professionals, alienate queer women from seeking healthcare, and discourage them from negotiating safer sexual practices with partners (see Hinchliff et al. 2005; Power et al. 2009; Scherzer 2000). A greater understanding of the ways in which queer women perceive sexual health and practice safer sex is necessary

for informing more inclusive healthcare and raising community awareness of queer women's health needs and practices.

A low perception of sexual risk among lesbians and their healthcare providers is apparent in much of the existing research from North America and the UK (see Fish and Wilkinson 2003; Formby 2011a; Logie 2014; Richardson 2000; Scherzer 2000). These low perceptions of risk, or as Dolan and Davis (2003) put it, the "lens of invincibility," significantly shapes queer women's sexual decision-making processes (Formby 2011a; Logie 2014). For example, the majority of Formby's (2011a) British respondents report using no barrier methods of safer sex, such as dental dams and/or gloves, when having sex with women (see also Cox and McNair 2009; Power et al. 2009; Richters et al. 2010). Instead, other social factors shape participants' sexual decision making, such as trust, perceived cleanliness/health of partner, relationship status, and known sexual history (Formby 2011a: 1171). Formby (2011a: 1172) and others (e.g. Logie 2014; Power et al. 2009) suggest that as a result of heterosexism, sexual health misinformation, and erasure, women in the queer community have not developed confident safer sex discourses and scripts to the same extent as gay men. Overall, insufficient targeting of sexual safety messages and a dearth of health promotion materials specifically for lesbian, bisexual and queer women have contributed to a poorer uptake of safer sexual practices among these groups (McNair 2009).

Although biomedical models of health assume a rational, responsible sexual actor, existing scholarship reveals that experiences of "safe sex" seldom reflect a rational decision-making process. For example, Bourne and Robson (2009: 283) suggest that the meaning of safe sex is not always clear, with further research necessary to examine how young people understand and negotiate these meanings. Bourne and Robson's (2009) study questions how a small sample of heterosexual and homosexual young adults in the UK conceptualise and experience "safe" sex. Drawing on Bloor's (1995) concept of "situated rationalities," Bourne and Robson's (2009) study reveals inconsistencies between the "biomedical safety rationale" and the participants' lived experiences

of negotiating safe sex (2009: 287). In line with Formby (2011a), Bourne and Robson's (2009) participants were aware of medical definitions of safe sex, however, many mentioned alternative experiences and understandings of what constitutes sexual safety in practice (see also Pilkington et al. 1994).

Bourne and Robson (2009: 287-289) found that, in addition to contraception and barriers to prevent STIs, participants highly valued trust and emotional safety as indicators of safe sex. This was especially the case for participants who were in long-term relationships, who often reported engaging in unprotected sex due to a heightened sense of trust and intimacy with their partner (291). Bourne and Robson (289) draw on Pilkington et al.'s (1994) concept of the "halo effect" to illustrate how participants' trust and faith in their partners, coupled with their belief in their partners' good nature, led participants to assume disease-free status and thereby rationalise the disuse of condoms. A number of studies similarly indicate decreases in use of barriers over the course of relationships, with condoms being seen as a sign of lack of trust and intimacy (see Beaulieu et al. 2010; Bishop 2013; De Visser and Smith 2000; Hillier, Harrison and Bowditch 1999; Senior et al. 2014). These findings suggest that "trust, as part of the romantic discourse, sits in competition with the scientific, decontextualised safe sex message in health promotion" (Bourne and Robson 2009: 291). In identifying the differences between biomedical and social definitions of safe sex and risk, Bourne and Robson's (2009) findings demonstrate how public health campaigns relaying a medicalised notion of safe sex are not always successful in improving sexual health.

While Bourne and Robson (2009) present useful explanations for inconsistencies between rational knowledge of safe sex practices and lived experiences of sex, the study has limitations. Despite including heterosexual and homosexual men and women in the study, the experiences of women who have sex with women were seldom discussed, the majority of their analysis focuses on heterosexuals' and gay men's experiences with condoms. This omission reflects broader discourses around safe sex and sexual health literature, perpetuating potentially harmful notions that women who have sex with women do not experience sexual

health risk. The erasure of lesbian, bisexual, and queer women from this discourse highlights the extent to which "safe sex" is a loaded term, reserved for certain people with certain bodies in particular contexts. Thus further work is required to specifically consider how lesbian, bisexual, and queer women conceptualise and experience safe sex.

Although gay and lesbian issues are increasingly present in health policy and practice, bisexuality remains largely obscured from mainstream concern, reflecting the relative dearth of research on the sexual health needs of bisexuals (for exceptions see Ebin 2012; Elia 2014). Although international scholarly attention to bisexuality and sexual fluidity has increased in recent decades (see Albury 2015; Boyer and Galupo 2015; Coleman-Fountain 2014; Hartman-Linck 2014; Hayfield et al. 2013; Pallotta-Chiarolli and Martin 2009; Wandrey et al. 2015) study of the specific sexual health experiences of bisexual and queer young women remains limited. Ebin (2012: 168) raised this issue by arguing that "it is essential to understand that the health of people who fall under the umbrella of the term bisexual is different from that of gay, lesbian and heterosexual people."

Bisexual people are often marginalised within LGBTIQ communities, services, and research due to negative stereotypes positioning them as promiscuous, confused, untrustworthy, and inauthentic (Pallotta-Chiarolli and Martin 2009: 206). While bisexual men are often pathologised as predatory or carriers for STIs or HIV/AIDS (see Worth 2003), bisexual women are accused of claiming a bisexual identity for attention (Alarie and Gaudet 2013; Burleson 2005), going through a "phase" (Diamond 2008), or putting on a performance to attract the heterosexual male gaze (Boyer and Galupo 2015; Fahs 2009). Sexuality and sexual health literature reflects and perhaps unintentionally exacerbates these negative stereotypes by invalidating bisexuality as a legitimate identity and through focus on bisexuals as a sexual health risk to others (Eliason 1997; Ochs 2011). Despite this stigmatisation of all bisexuals as "infection bridges," sexual health literature also largely focuses on bisexual men (Martinez et al. 2012; Worth 2003). Few studies directly examine bisexual women's experiences of

sexual health in isolation from lesbians (e.g. Mulligan and Heath 2007).

Previous studies importantly identify significant concerns in the area of bisexual mental health, with bisexual and queer women reporting higher rates of depression, low self-esteem, and lower likelihoods of self-disclosure and community connection compared to gay men and lesbians (Balsam and Mohr 2007; Galupo 2006). Bisexual women report higher experiences of sexual violence and intimate partner abuse, reduced likelihood of engaging with targeted healthcare supports (see Flanders et al. 2015; Mulligan and Heath 2007; Pallotta-Chiarolli and Martin 2009), and exhibit higher rates of numerous health risk behaviours such as smoking, drug use, and unprotected sex (Galupo 2006; McNair and Hegarty 2010). This highlights the importance of examining bisexual and queer experiences in isolation from broader LGBTIQ studies to capture the specificity of experiences under the plurisexual umbrella (Ebin 2012). Similarly, further Australian research is needed into the sexual health experiences and concerns of bisexual and queer women given the limited Australian research and health support in this area.

Queer Women's Sexual Health in Australia

Until recently, the dearth of systematic research on Australian queer women's health has been a significant barrier to understanding and addressing the health needs of this population (Mooney-Somers et al. 2017: 1). The Sydney Women and Sexual Health (SWASH) study is a comprehensive survey of lesbian, bisexual and queer women's health issues, providing important epidemiological data on sexual health, mental health, tobacco, drug and alcohol consumption, and cancer screening behaviours. Conducted biannually since 1996, the 2014 survey found that 20 per cent of women had never had a pap smear and 40 per cent had never had an STI test, despite the majority being sexually active with both genders (Mooney-Somers et al. 2017). Although the women's knowledge of STIs was better overall than that of women in the general community, safe sex equipment such as dental dams and gloves were rarely used (see also Richters et al. 2010). Only 32 women reported having ever used a dental dam, with most having only

done so once (Mooney-Somers et al 2017). Richters et al. (2010) posit that these one-time dental dam users do so out of curiosity rather than being driven by safe sex considerations.

In their large-scale survey of Australian LGBTIQ youth, Hillier et al. (2010) found that queer young women are more likely to engage in unsafe/unprotected sex at an earlier age than their heterosexual peers, placing them at greater risk of unplanned pregnancy, sexual violence or coercion and STI contraction (see also Dempsey et al. 2001). Hillier and Mitchell (2008) also found that, like similar studies in the UK (e.g. Formby 2011b), LGBTIQ young people receive insufficient sex education in schools, placing them further at risk of marginalisation and poor sexual health and wellbeing (see also Jones and Hillier 2013; Jones et al. 2016).

In an earlier study, Dempsey et al. (2001: 73) found that young gay men are significantly more likely than young women to report having "always known they were gay." For Dempsey et al. (2001: 73), this is due to hegemonic masculinity being constructed as strictly heterosexual, with any gender-non-conforming behaviour in boys being interpreted as "gay." Whereas, for queer young women, childhood displays of masculine or other gender non-conforming behaviours are often interpreted as being a "tomboy", which does not necessarily destabilise compulsory heterosexuality for girls, with many not realising their same gender attractions until much later in life (Dempsey et al. 2001: 73). These gendered complexities are arguably reflected in the higher rates of young women than men identifying as bisexual, queer or other in a number of recent major studies of sexuality (see Richters et al. 2014; Robinson et al. 2014).

While there have been a number of significant quantitative Australian studies of sexuality and sexual health, there is limited in-depth qualitative research in this area. Most qualitative research on sexual health focuses on heterosexual subjects. Existing literature highlights that, due to the gendered, social nature of (hetero)sexual relations, (e.g. condom negotiation) there are many factors, other than basic knowledge, that influence sexual health outcomes (see Amaro 1995; Bishop 2013; Bourne and Robson 2009; Curtin et al. 2011; Zukoski et al. 2009).

In light of this, I argue that qualitative methodologies are useful for researching sexual health conceptualisations, negotiations and experiences, as they are not necessarily constituted by rational, quantifiable categories of experience. Qualitative data can usefully lead to deeper understandings of the individual meaning-making around sexuality and sexual health.

Power et al. (2009) conducted an important study using qualitative interviews and a survey to analyse Australian lesbian and bisexual women's knowledge of and attitudes toward Human Papillomavirus (HPV) and Pap testing. A key finding is that participants perceive a low sense of vulnerability to STIs, such as HPV, assuming that many sexual health concerns did not apply to lesbians (2009: 74; see also Formby 2011a). These misconceptions are fuelled by misinformation from doctors, who are, in many cases, complicit in perpetuating lesbian and bisexual erasure in the context of sexual health (2009: 73). For example, one lesbian participant reports that her doctor incorrectly told her she did not need a pap test since she had never had sex with men (2009: 73-74). Lesbians and bisexual women in Power et al.'s (2009) study internalised heterosexist definitions of sexual activity in the medical context, leading to their perception of low vulnerability to sexual health concerns and an overall lack of knowledge and prioritisation of safe lesbian sex. Often, because lesbian sex is positioned as not legitimate sex in heterosexist contexts, women see sex with women as inherently safe, or struggle to define what even constitutes safe lesbian sex (2009: 76).

While this section has outlined the existing body of queer women's health research in Australia, knowledge gaps remain. Comparatively little research specifically examines Australian bisexual and queer women's sexual health. With a few exceptions (e.g. Power et al. 2009; Richters et al. 2005), to my knowledge, no studies qualitatively examine queer young women's sexual health in Australia. Similarly, there is a dearth of Australian sociological research examining queer women's health experiences in regional and rural areas. The next section examines sexual health in Tasmania to show why Tasmania is an intriguing site to explore LGBTIQ health politics.

Tasmanian Sexual Health

Studying the sexual health and healthcare experiences of queer women in Tasmania is important because of the dearth of qualitative LGBTIQ health research conducted in rural and regional Australia. Although Tasmania experiences many of the socio-economic and health issues common in rural areas, there are a number of issues specific to Tasmania. Tasmania is mostly rural - the state capital of Hobart (approx. pop: 218,000) is classed as metropolitan according to the Rural, Remote, and Metropolitan Areas Classification (RRMA), with the majority of the state being rural and remote (Australian Institute of Health and Welfare 2017). The Tasmanian population is rapidly aging and highly decentralised, with 57 per cent living outside the greater Hobart region (ABS 2017b). Like other rural Australian communities, Tasmania has a higher unemployment rate, lower levels of post-school qualifications, and lower weekly earnings than the Australian average (ABS 2012b). Additionally, Tasmania has some of the highest rates of obesity, smoking, and sedentary lifestyles in the country (ABS 2010; 2014a). Compared with other states, Tasmanians are more likely to report living with long-term health conditions, such as disabilities, mental health issues, and chronic illness (ABS 2014b).

Given the state's decentralised population, it is perhaps unsurprising that Tasmanians report increased difficulties in accessing health services (ABS 2014a). In some parts of Tasmania access to healthcare is limited, with less than 66 full-time general practitioners for every 100,000 people (Department of Health and Human Services [DHHS] 2009a). Tasmanians subsequently consult healthcare providers less often than the Australian average and are heavy consumers of over-the-counter medications (ABS 2010; DHHS 2013). While nation-wide notifications for STIs such as Chlamydia are rising, especially among young women, Tasmania's notifications are slightly lower than the national average. However, lower rates of healthcare access and preventative screening may contribute to this data (ABS 2012b). Although national rates of teenage

pregnancy have declined, Tasmania continues to have the second highest level of youth pregnancy (see ABS 2016) and higher than average rates of smoking during pregnancy (DHHS 2016).

There are a number of government initiatives to combat the state's health concerns, such as the Leading The Way (DHHS 2009b) taskforce and the more recent Healthy Tasmania Plan (DHHS 2016). Both of these initiatives focus on priority areas of reducing smoking and obesity and supporting the state's aging population (see DHHS 2013). Yet these plans are highly politicised and have problematically failed to directly engage with and address the social determinants of health in Tasmania by deploying a neoliberal, biomedical view of health and illness common in public health policy (for an exception, see DHHS 2013). These initiatives also neglect to meaningfully engage with gender and sexuality in the Tasmanian population. For example, the Tasmanian Women's Plan (Department of Premier and Cabinet 2013) does not include women's sexual and reproductive health as a target area, despite this being listed as a priority in both the National Women's Health Policy (Department of Health 2010) and the Australian Medical Association's position on women's health (2014). I was interested to explore Tasmanian young women's experiences of sexuality and sexual health in this context and chose to focus specifically on queer women's experiences as I noticed that queer young women's health is invisible in Tasmanian public health discourse.

The few qualitative studies examining experiences of sexuality and sexual health in Tasmania focus entirely on heterosexual experiences (see Bishop 2013; Warr and Hillier 1997). Bishop's (2013) study of safe sex strategies among heterosexual young people in rural Tasmania is one of few studies that have focused on sexual health in the Tasmanian context (see also Warr and Hillier 1997). This study is significant in its intent to challenge the predominance of negative risk discourses around rural youth sexuality which Bishop (2013: 124) claims stigmatise rural youth health strategies.

Bishop (2013) found that participants' "unsafe" or "risky" sexual experiences

(e.g. casual sex without protection) are not necessarily driven by lacking knowledge of sexual health. Instead, many complex social factors shape young people's sexual communication and decision-making processes. Bishop (2013) found that gender plays a significant role in shaping participants' abilities to perform safe sex in rural contexts, with young women being stigmatised as "sluts" for actively negotiating the use of condoms and worrying about the lack of anonymity in accessing sexual healthcare while living in small towns (see also Hillier et al. 1999; Senior et al. 2014; Warr and Hillier 1997). Although Bishop (2013) and Warr and Hillier's (1997) studies only observe heterosexual relations, I argue that, from their findings, it may be hypothesised that queer young women might experience similar difficulties accessing sexual healthcare in Tasmania.

Queer Women and Their Health Care Providers

This section reviews research on medical practitioners' approaches to treating LGBTIQ patients. Given queer women's specific health concerns, the focus here is on how women and their healthcare practitioners negotiate inclusive care. Compulsory heterosexuality isolates queer women from sexual healthcare and positions their experiences as deviant from the norm (McNair 2003). The medical and scientific communities have long played a role in pathologising LGBTIQ patients, contributing to broader social stigma, medicalisation, and persecution of LGBTIQ communities (Mulligan and Heath 2007). Historically, lesbianism was positioned by medicine as a "disease" or "disorder," with medical practitioners openly discriminating against lesbian patients and employing aversion therapies, such as lobotomies, hysterectomies and electroshock therapy to "cure" lesbians of their "deviancy" (see Fish 2006). During the mid-twentieth century, lesbian feminists campaigned against this pathologisation of lesbianism, with homosexuality being removed from the American Psychological Association Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973, with the Royal Australian and New Zealand College of Psychiatrists shortly following suit. As I will discuss in Chapter 6, LGBTIQ-inclusive medical practice is now included in the policy and practice guidelines of the Australian Medical Association (AMA)

and the Royal Australian College of General Practitioners (RACGP).

Despite growing acceptance, the continuing effects of institutionalised homophobia and transphobia result in significantly reduced engagement with healthcare among LGBTIQ people (for overviews, see Cox and McNair 2009; Hagen and Galupo 2014; McNair 2003; Pitts et al. 2009; Richters et al. 2010). Furthermore, while societal attitudes to homosexuality may be shifting, institutional heterosexism persists in the medical professions, with studies indicating short-comings in LGBTIQ-inclusive medical training internationally (Hinchliff et al. 2005; Jones et al. 2002; Obendin-Maliver et al. 2011). Therefore, further research is required to address knowledge gaps.

In one of the earliest studies to directly focus on queer women's experiences of sexual healthcare, Scherzer (2000) identifies structural and interpersonal factors impacting young queer women's experiences and access to healthcare in San Francisco in the US. Scherzer (2000: 90) conducted qualitative interviews with eight lesbian and bisexual women between the ages of 18 and 21 in the late 1990s with a view to understanding how young queer women understand, experience, and relate to health. A key finding is that common past experiences of negative, homophobic or dismissive healthcare interactions significantly deter young queer women from re-entering healthcare settings (2000: 88). Participants discussed incidents where healthcare providers "articulated heterosexist assumptions that negated and stigmatised young women's queer sexuality, and failed to acknowledge health issues for lesbians" (Scherzer 2000: 93). In these cases, queer women relied on their lay understandings of health and illness, reporting distrust of Western medicine and a preference for "taking care of yourself" (2000: 91-92). However, despite these discourses of self-reliance and responsibility, participants report a number of poor sexual health outcomes or a lack of understanding of sexual health and safe sex practices (2000: 91). Reporting knowledge of safe heterosexual practices is common, however there are very few common strategies or understandings of how to practice safe sex with female partners (2000: 91).

Scherzer's (2000) US study is significant because it highlights the importance of healthcare provision that is sensitive and informed about LGBTIQ experiences, issues and concerns, especially for young queer women who experience a range of specific health risks that require sensitive, holistic treatment (e.g. STIs, mental health, sexual assault and trauma, illicit substance use, reproductive health). Despite its small sample, Scherzer's (2000) study raises some important questions and implications for further research. Scherzer's study is based in a large North American city renowned for its active LGBTIQ culture, history, and community (2000: 89). In light of this, this thesis examines how experiences and access to queer-friendly healthcare might be different in areas with a less well-established queer community, in particular, rural and regional areas. Scherzer (2000: 99), herself, questions: "for young queer women living in situations or locations in which it is far less safe to be young, female and queer, what does health mean? How is healthcare negotiated with healthcare providers?" These questions directly inform the development of this thesis in the Tasmanian context.

In addition to the growing body of work examining queer women's experiences of health and wellbeing and healthcare (see Austin 2013; Formby 2011a; McNair 2009; Mulligan and Heath 2007; Munson and Cook 2016; Koh et al 2014), studies also examine healthcare providers' knowledge, attitudes, and experiences treating LGBTIQ patients. Mirroring much of the previous work outlining queer women's discomfort and mistreatment from doctors (see Austin 2013; Formby 2011; McNair 2009; Mulligan and Heath 2007; Munson and Cook 2016; Koh et al. 2014), studies assessing practitioner knowledge and attitudes indicate that practitioners seldom feel comfortable and competent to treat lesbian, bisexual, and queer women. Hinchliff et al.'s (2005) study of British GPs' perspectives on discussing sexual health with gay and lesbian patients reveals a lack of competency with LGBTIQ issues and needs, resulting in practitioner discomfort and reduced care (see also McNair et al. 2015). However, many of Hinchliff et al.'s (2005) participants express willingness to improve their ability to provide culturally sensitive care for gay and lesbian patients but identify a lack of training at undergraduate level and a lack of time for vocational re-skilling as

barriers to improvement.

Obedin-Maliver et al.'s (2011) survey of 150 North American medical schools supports Hinchliff et al.'s (2005) conclusions. Obedin-Maliver et al. (2011) observe that an average of just five hours is dedicated to teaching LGBTIQ health content and inclusive practice across the entire undergraduate curriculum at these institutions and the majority only rated this content as fair in quality. Evidence suggests that inadequate curriculum development and teaching activities shape medical students' attitudes towards LGBTIQ patients. For example Burke et al.'s (2015) study of US medical undergraduates shows that nearly half (45 per cent) of those surveyed hold explicit bias against LGBTIQ people, while the majority (82 per cent) hold some implicit or unconscious bias. Similarly, Jones et al.'s (2002) study of Australian medical students' attitudes toward lesbian and gay patients reveals high levels of discomfort when discussing sexuality and sexual health issues with non-heterosexual patients. Female medical students report especially negative attitudes towards treating lesbian patients (Jones et al. 2002: 80), a concerning finding given lesbian and queer women's reported preference for seeing female doctors (Scherzer 2000).

Negative attitudes from medical practitioners contribute to barriers to healthcare faced by lesbian, bisexual and queer women and exacerbate the stigma and health disparities they experience. According to Formby (2011a: 1171), sexual health provisions for queer women are often influenced by biomedical discourses that focus on "lack." For example, lesbians experience a "lack" of heterosexual intercourse and therefore a perceived lack of need for treatments and screening. Such assumptions also arguably influence the dearth of sociological and health research and social policy addressing queer women's experiences and concerns in this area. In line with previous work in this field, Formby (2011a) finds that British lesbians expect heterosexism and homophobia in healthcare contexts, resulting in lesbians being significantly more less to either report their sexuality to doctors and receive quality sexual health advice and treatment, with many avoiding preventative healthcare altogether (see also Mulligian and Heath 2007; Richters et al. 2010). Like Scherzer's (2000)

participants, hearing about other lesbians' negative experiences with doctors led Formby's participants to delay treatment regardless of experiences of their own (Formby 2011a: 1174). This raises the question of how to design, conduct, and present social research on queer women's sexual health that builds resilience and raises awareness of the issues that queer women face, while not perpetuating their marginalisation and subsequent avoidance of sexual healthcare.

In this chapter, I situated this thesis theoretically, through a discussion of neoliberalism, post-feminism, and intersectional queer theory. The following chapters use Munoz's (1999) disidentification theory to examine how queer young women understand sexuality and sexual health in the Australian neoliberal, post-feminist context. The next chapter describes the methodological approach to this project, reflecting on the research design and process.

Chapter 2: Methodology

Introduction

Brooks and Hesse-Biber (2007: 3) describe feminist research practice as "a holistic endeavor that incorporates all stages of the research process, from the theoretical to the practical, from the formulation of research questions to the write-up of research findings." In this chapter, I discuss my own "holistic endeavor" in conducting feminist qualitative research, providing an overview of the structure and design of the research and outlining the methodological approach and strategies that have shaped the project. To begin, I discuss feminist, intersectional, and queer methodologies and how these shaped the conduct and design of this project. I then describe my participant selection strategies and experiences of semi-structured, in-depth interviewing, transcription, and analysis informed by feminist research practice. In the final section, I reflect on the research process, considering the limitations of this study and applying an intersectional feminist approach to acknowledging researcher standpoint.

Methodology

Approaching my doctoral research I knew that my personal, political, and academic commitments as a feminist would inevitably shape my approach to the research. Bryman (2007: 16-17) refers to this as acknowledging one's "methodological identity" - recognising that our prior epistemological, ontological, and axiological commitments influence how researchers conceptually approach and practically conduct qualitative sociological research. Thus, I sought to explore the meaning of conducting social research as a feminist and to identify the defining features of feminist research methods. I discovered that feminist research can be understood as much more than simply research conducted by feminists (see Reinharz 1992: 6), but multiple, distinct, and nuanced methodological and ethical approaches to research project design (see

Brooks and Hesse-Biber 2007). In this section, I explore intersectional feminist and queer methodologies and describe how they influenced this thesis.

Feminist sociologists argue that in the attempt to position sociology as a hard science, modern sociological theory and empirical research methods have been determined by the interests and experiences of men (Smith 1987: 61; see also Oakley 1981). Feminist approaches to social science research seek to make women's experiences visible, to prioritise women's empowerment and to draw attention to the patriarchal gender order both in society and in academic research settings (Brooks and Hesse-Biber 2007; Roberts 1981). For example, in dominant western epistemologies, rational, objective truth is prioritised over emotional, embodied experiences (Roberts 1981; Smith 1987: 30). In contrast, feminist epistemologies value subjectivity, embodied knowledge and multiple forms of truth (see Reinharz 1992).

A key aspect of most feminist methodologies is the intent to challenge positivist epistemologies of who can be a "knower" and what can be "known" in the context of the research relationship – a relationship often shaped by unequal power dynamics. In her germinal essay, 'Interviewing Women: A Contradiction in Terms,' British feminist sociologist Ann Oakley (1981: 37) exposes the "proper" social science interview as problematic for feminists due its hierarchical positioning of the researcher/interviewer as an "expert" gatherer and recorder of data, while interviewees are constructed as passive sources of data and objective truth. For feminists, this "proper" sociological interview reflects and is influenced by traditional gender stereotypes that create an unequal power relationship between the (historically male) researcher and the (historically female) "researched" (Browne 2003: 141). Feminist research methods emphasise the importance of analysing, addressing, and deconstructing these power disparities in the research relationship, aiming to foster reciprocity and engagement between the researcher and participants, who act as co-investigators (Oakley 1981; Reinharz 1992: 27).

While traditional approaches stress the need to avoid becoming personally

involved with research participants, lest the “hard won status of sociology as a science” be jeopardised (Oakley 1981: 41; see also Perry et al. 2004), feminist and queer researchers emphasise the importance of reciprocity, empathy, and respect in the research relationship (Rubin and Rubin 1995: 37). Feminist researchers emphasise the importance of a reflexive, sensitive, and empathetic approach to qualitative interviewing, where participants are treated as friends (see Browne 2003). As Cowden suggests, “we can only understand organisms by seeing with a loving eye” (1984 cited in Reinharz 1992: 3). Therefore, feminist projects often employ qualitative methods such as interviewing, life histories, and conversation analysis. These encourage collaboration between researchers and participants, who co-construct knowledge from their own lived experiences, rather than collect them objectively as quantifiable “data” from “out there” (Brooks and Hesse-Biber 2007: 13).

Just as feminist sociologists have argued that modern sociology largely ignored the experiences of women (see Oakley 1981; Smith 1987), gay and lesbian scholars and queer theorists have exposed the heteronormativity of the discipline (for a comprehensive overview, see Seidman 1997; Weeks 2003). Influenced by post-structuralism and feminist theory, queer methodologies radically reject the possibility of obtaining objective truth through scientific observation. Instead, emphasis is placed on multiplicity and intersectionality of identities and experiences (see Butler 1991; Fuss 1991; Weeks 2003). For example, Kong et al. (2001: 248) argue that the purpose of queer interviewing "is to subvert the unified notion of gay and lesbian identity and to paint a picture of multiple and conflicting sexual/gendered experiences.” Therefore, queer approaches position identities not as static truths but as fluid and multiple, thereby challenging the “regulatory regimes” that enforce compulsory heterosexuality (Butler 1991: 13; see also Fuss 1991; Rich 1986). For these reasons, Levy and Johnson (2011: 134) argue that queer methodologies are “strategic and political,” as they promote constructive discourse, challenge social norms and binary ontologies, and call for new ways of conceptualising social phenomena - a key reason I adopted them in this research.

As outlined in Chapter 1, feminism and queer theory are critiqued for privileging white, middle-class subject positions (see Moraga and Anzaldúa 1983; Cohen 1997). An emerging body of work draws attention to the use of intersectional methodologies in queer studies to address these critiques (see Taylor et al. 2010). Intersectionality has been widely examined as a theoretical, analytical, and epistemological framework, but it has been seldom framed as a methodology (Bauer 2014). Intersectionality raises important methodological questions about how to analyse multiple intersecting and mutually constituting categories (see Hancock 2007; McCall 2005; Nash 2008). While "unitary" research methods focus on one variable, or category of analysis, and "multiple" approaches consider how more than one category shapes social experience, intersectionality calls for an alternative approach (Bauer 2014: 11; Hancock 2007). Intersectional feminist scholars have argued for a more complex understanding and application of intersectionality beyond "additive" models (see Bowleg 2008). Instead, an "intercategorical" approach to intersectionality allows researchers to examine how multiple social categories and experiences are mutually constituted (McCall 2005). For Bauer (2014: 11) this is valuable because it encourages a more nuanced understanding of how multiple identities intersect and shape each other.

While intersectionality offers an important theoretical framework in feminist and queer studies, many have critiqued its practicality as a methodology. As Nash (2008: 11-13) outlines, merely recognising the multidimentionality of identity is methodologically vague, leaving us asking "so what?" Indeed, in considering how to practically incorporate intersectionality into this research, I faced difficulty articulating what form this would take. For Hancock (2007), the number of social categories is a methodological challenge in intersectional analyses. Christensen and Jensen (2012: 112) question whether this makes the concept unwieldy, with the potential for certain categories being prioritised or strategically selected over others. Is it practical to examine all possible subject positions and their potential intersections? How do intersectional researchers select which categories to focus on without succumbing to reductive, additive models? Furthermore, how do they account for their own positions in making

these value-laden methodological decisions? Puar (2007: 23) similarly argues that while intersectional queer theorists like Cohen (1997) assume that situating queerness in intersectional models will challenge race and class norms as they intersect with heteronorms. However, in reality, white queer thinkers often privilege resistance to heteronorms in a way that disregards the effects of this in relation to other norms such as racial, class, gender, and citizenship privileges (Puar 2007: 23; see also Riggs 2010).

Another methodological critique of intersectional analysis is that it has been predominantly used as a framework to examine marginalisation, with few scholars turning the lens towards experiences of privilege (for exceptions, see Carbado 2013; Riggs 2010). This has arguably left the "normality" of majority groups unquestioned (Choo and Ferree 2010; Nash 2008; Yuval-Davis 2011). Subsequently, critical race theorists argue that the centrality of white women (which intersectional feminist politics initially aimed to subvert) has been re-secured through mainstream deployment of intersectionality (Puar 2013: 373). In this thesis, I aim to contribute to addressing these methodological challenges through my intersectional feminist approach to queer women's lived experiences of health and sexual citizenship.

Drawing on these methodological critiques, I considered how intersectionality could be used as part of the research methodology for this research. Davis (2014: 27) argues that intersectional "methodologies should raise new questions, engage reflexively and critically with previously held assumptions and explore unchartered territory." For Davis (2014: 25), one way to practically apply intersectionality is to engage in an exercise she refers to as "asking the other question." Matsuda (1991, cited in Davis 2014: 25) demonstrates this process: "when I see something that looks racist, I ask, 'Where is the patriarchy in this?' When I see something that looks sexist, I ask 'Where is the heterosexism in this?'" According to Davis (2014), this process encourages the use of intersectionality as a "creative methodology" – a critical and reflexive process that allows for exploring the complex interconnections of all forms of subordination. I employ this kind of reflexive analysis throughout the thesis,

paying particular attention to how positions of race and class privilege intersect with white young women's experiences of queerness in rural Australia. Another practical strategy Davis offers is to prioritise intersectionality through situating oneself in the research. Rather than merely listing one's positions (e.g. I am a white, middle-class, bisexual woman), Davis (2014: 29) calls for a deeper reflection on researchers' "social geographies" that is integrated into the research process. In line with my feminist methodology, I deeply considered my researcher standpoint at all stages of this research, as I will discuss later in this chapter.

When conducting sensitive qualitative research, Levy and Johnson (2011: 134) stress the ethical imperative for intersectional feminist and queer researchers to become advocates for those who they study and I took this as a central methodological aim for my thesis. I practically incorporated these aspects of intersectional feminist and queer methodologies (promoting rural queer women's voices, challenging research power dynamics, and conducting research in a reciprocal, friendly manner) into my research design through a prioritisation of reflexivity, integrity, and commitment throughout the research process. In the following section, I describe my practical approach to the research, using snowball and purposive sampling approaches to recruit participants and conduct semi-structured, in-depth interviews with these methodological commitments in mind.

Method and Design

Participant Recruitment and Issues of Access

Participants were recruited using purposive and snowball sampling methods. Snowballing is a technique often used when researching groups that may be hidden or hard to access, but is also fruitful in making use of participants' shared identity and group membership (Babbie, 2014: 200-201; for examples, see Brown-Saracino, 2014). Through my involvement in the local LGBTIQ community, I made use of my personal and professional networks and the often "close-knit" nature of rural

LGBTIQ communities (see Kazyak 2012). This process involved placing advertisements (see Appendices A-B) inviting potential participants to contact me in public places (university campus, health clinics, local organisations), targeted social media advertising in LGBTIQ social groups, and in-person recruitment at social events hosted by a local LGBTIQ advocacy organisation. All contact with participants was conducted via email or direct messaging through a Facebook page that I established to promote the research. Given the focus of the study, inclusion criteria were self-identified women aged between 18-30 years, "same-gender attracted" or LGBTIQ, with experience accessing sexual healthcare in Tasmania. Sample size was based on consideration of the study design, nature of the topic, and quality of the data.

While this approach may produce sample bias for some studies, my approach to qualitative research values the multiplicity of experiences and does not seek to gain an objective, quantifiable or generalisable truth (Gamson 2000: 359). Furthermore, attempting to gain a representative or probability sample in a study like this is unfeasible as there are no constant and clear boundaries to the population being studied, even among members of the group (see Fish 1999; Stein 1997). However, my approach is limited by the fact that I was more likely to recruit participants who were vocal, confident, and engaged in the "queer scene." As Kitzinger (1987) similarly observed, such approaches are more likely to garner white, middle-class, urban and highly educated samples. Self-selected methods are also unlikely to appeal to those in the LGBTIQ community who are "closeted," or not open about their sexuality or gender identity. These shortcomings are reflected in my sample, as those opting in were more likely to be white and from urban, middle class backgrounds.

While other studies of this type report recruitment difficulties given the hidden population being studied (e.g. Brown-Saracino 2014; Hayfield et al. 2013), I generally found women enthusiastic and eager to come forward. However, accessing potential participants from rural areas in the North of Tasmania was more challenging than recruiting in the capital city of Hobart in the South. As Kong et al. (2001: 252) outline, "although being members, or keen supporters, of particular gay communities may provide researchers with some important

insider contacts, this is no assurance that the researchers' location within these communities will mark the beginning of successful research recruitment." Despite being a member of the LGBTIQ community in the South, this did not guarantee easy access to the community in the North, with potential participants perhaps seeing me as a geographical "outsider" (see also Brown-Saracino 2014). Because of my lack of geographical connection with the LGBTIQ community in the North of the state, I could not rely on my social contacts as I had done in the South. In order to establish trust and rapport with young people in the community, I attended queer youth support groups in Launceston and Burnie to speak about my project. This was a successful recruitment technique. A number of women subsequently agreed to be interviewed and recommended me to their friends.

Early in the planning stages of this research, I identified language, identity, and naming as potential issues for participant recruitment. What was the correct or most appropriate language to use in order to recruit and represent my target population? In discussing my research with non-academics, I often found it difficult to convey whom exactly it was that I was researching without being met with confusion or concern. One older lesbian working in the healthcare sector found my use of the term "queer" off-putting, given its history as a homophobic slur. In contrast, young, politically active queers found terms like "same sex attracted" conservative and reductive. Even my use of the acronym "LGBTIQ" confused some people who were unfamiliar with the movement - my inclusion of "Q" for queer, proving especially intriguing to some (see also Levy and Johnson 2011).

These issues of language resonated with me throughout the recruitment phase of the research. While I use "LGBTIQ" throughout this thesis, it is worth noting that the acronym varies depending on its author, audience, and context. In some, often institutional, contexts the acronym is merely "LGBT" or "LGBTI," perhaps reflecting the lack of awareness of intersex individuals and this inaccessibility of "queer" to broader audiences. In some highly politicised queer or activist environments, the acronym is expanded to "LGBTQIAP+" to include pansexual,

asexual, and aromantic people and, for some, heterosexual "allies" in the community. As I will explore in depth in Chapter 3, one participant captured the perils of the "alphabet soup" of queer identity politics and language (see also Ghaziani 2011), as they lamented: "It's such a shame we can't find a term that really includes everybody."

Earlier research has used "lesbian" as a blanket term when recruiting (see Esterberg 1997; Fish 1999; Kitzinger 1987; Stein 1997). However, I was concerned that this singular label did not include the range of identifications and experiences I wanted to capture. In comparison, Brown-Saracino (2014: 51) recruited using a self-selected strategy, asking: "do you identify as lesbian, bisexual, queer or transgender?" In the current climate, perhaps a legacy of queer theory, LGBTIQ identities are becoming numerous and increasingly fluid, so I was conscious of not using reductive or fragmentary identity categories to "pigeon hole" participants (see Stein 2010). I considered the consequences of recruitment materials using language that potential participants may not identify with, for example, not all women who have sex with or are attracted to women identify with terms like "lesbian" or "queer" for a number of reasons. Subsequently, my recruitment materials called for participants who identified as women who are "same gender attracted," followed by the clarification: "you might identify as lesbian, gay, bisexual, pansexual, asexual, transgender, queer, non-binary and many more!" to give potential participants a sense of the kinds of people I was looking for and to show that I was open to the multiplicity of queer identities.

Recruiting Professionals

To gain insight into how the Tasmanian health system is accommodating the needs and concerns of queer young women, I conducted additional interviews with six medical doctors. General practitioners were recruited through a process of purposive and snowball sampling techniques. Staff at the state-wide LGBTIQ advocacy group provided me with a list of general practitioners who had been recommended by their clients as clinics or individuals providing LGBTIQ-

inclusive care. All the medical professionals on the list were contacted by email and/or post with a letter of invitation to participate in the study.

This approach was limited in that it produced a biased sample, with only health professionals with interest and experience working with the LGBTIQ community being likely to take part. However, given the topic and kind of information being gathered (e.g. approaches to LGBTIQ-inclusive practice), it was unlikely that health professionals who were not inclusive of the LGBTIQ community would self-select into such a study, nor would they be able to provide useful data if they had little or no experience in the area. Furthermore, rather than gaining a representative sample of Tasmanian healthcare practitioners (which is beyond the scope of this thesis), I sought to establish a qualitative "snap-shot" of a small sample of practitioners' approaches to inclusive practice. The aim of this was to provide supplementary, exploratory data to complement the interviews with women and to generate new pathways for future research.

Although contacting medical doctors who were listed as providers of inclusive practice produced a biased sample, this did not necessarily mean that all doctors were, in fact, inclusive and experienced in treating members of the LGBTIQ community. A common reason many participated was to gain further information about how to provide culturally competent care for their existing patients. Because of this, I gained a sense of both how average general practitioners with fairly little LGBTIQ-specific expertise were approaching consultations with LGBTIQ patients, in addition to hearing from more experienced practitioners.

Participants

I interviewed 21 participants between October 2015 and April 2016, including 15 women and six general practitioners. At the beginning of interviews with women, with their consent (see Appendix E), I collected demographic details about each participant (see Appendix G). Some basic information about the women I interviewed, including their age, sexuality, race/ethnicity, geographical

region, and highest attained educational qualification, are listed in the table below. The questionnaire used to gather this information featured open-ended questions to allow participants to use their own words to describe themselves. I also invited participants to choose pseudonyms for themselves, which are used throughout the thesis. While I am wary of reducing participants to simplistic categories, this information does give the reader a picture of the kinds of people who agreed to participate in the study.

	Age	Sexuality	Ethnicity	Education	Region
Pip	20	Pansexual	White	High school	North
Jess	25	Bisexual	Italian	TAFE	South
Harley	19	Asexual	White	TAFE	North
Isabelle	21	Queer	White	High school	South
Miki	25	Bisexual	White	TAFE	South
Middy	19	Fluid	White	TAFE	South
Max	21	Bisexual	White	High school	South
Stella	26	Bisexual	White	Bachelor	South
Audrey	20	Bisexual	White	High school	South
Jayden	20	Pansexual	White	High school	South
Carrie	23	Bisexual	White	Bachelor	South
Frankie	25	Bisexual	White	Bachelor	South
Sloane	26	Queer	South Asian	Postgraduate	South
Evie	26	Pansexual	White	Bachelor	South
Francesca	20	Pansexual	White	TAFE	North

As I will discuss in detail in Chapter 3, unlike earlier studies of this kind (e.g. Brown-Saracino 2014; Esterberg 1996; Kitzinger 1987; Richters et al. 2005; Stein 1997) no participants currently identify as lesbian, with the majority identifying as bisexual or pansexual. In line with dominant definitions (e.g. Callis 2014; Gonel 2013) participants understand pansexuality as romantic and/or sexual attraction to people of any/all genders, or people regardless of their gender. Similarly, participants identifying as "queer" frame their plurisexual attractions as being fluid and intentionally disruptive of sexual and gender categories. As I will discuss in Chapter 3, bisexual women frame their identity in similar ways to pansexual women, but many choose to continue using the term "bisexual" (rather than "pansexual" or "queer") to advocate against bi-erasure (Comeau 2012) or to combat attitudes that bisexuality only involves attraction to cisgender men and women (Gonel 2013). These findings are concurrent with

trends in recent larger scale Australian social research, which is increasingly finding young people identifying with more fluid sexual and gender identities (see Hillier et al. 2010; Robinson et al. 2014). Queer scholarship and empirical research has been critiqued for focusing on a white, middle-class cohort (see Cohen 1997; Muñoz 1999). Two participants identified as women of colour, with the majority identifying as white. As is often the case in research of this kind, the racial homogeneity of my sample is one limitation of this study. Participants are highly educated, positioning them as middle-class. Five participants had a bachelor degree or higher and six of the ten participants with high school or vocational (TAFE) qualifications were undertaking further study at university.

Some basic demographic details about the GP participants are provided in the table below. The six practitioners were purposively sampled from a list of doctors who were nominated for industry awards recognising excellence in LGBTIQ-inclusivity in Tasmanian health services. Five are established GPs and one is a GP registrar, all practicing in Hobart and the surrounding suburbs. One GP also practices in a rural health service in Southern Tasmania. Three participants had pursued additional training and certification in family planning, sexual health care, and women's health. Four have received some vocational training in LGBTIQ-inclusive practice in Tasmania.

	Age (approx.)	Gender	Occupation	Region
Dr R	40s	Male	General Practitioner	South (Urban)
Dr N	30s	Female	Registrar	South (Urban)
Dr C	40s	Female	General Practitioner	South (Rural)
Dr F	40s	Female	General Practitioner	South (Urban)
Dr O	50s	Female	Sexual Health	South (Urban)

			Specialist	
Dr E	40s	Female	Sexual Health Specialist	South (Urban)

This information was gathered through conversation rather than a demographic questionnaire as part of building rapport with the practitioners at the beginning of our interviews. While I initially believed a conversational approach might help set the tone for our interviews, in retrospect, implementing the same demographic questionnaire used for the young women would have saved time and provided richer background data on these practitioners. For example, very few studies have collected data on healthcare providers' sexualities (for an exception, see McNair et al. 2015) and doing so may shed important light on how doctors relate to LGBTIQ patients and inclusive practice (Hinchliff et al. 2005: 352). It is possible that some participants were lesbian, gay, or bisexual, but I regrettably did not ask directly for their sexual orientation.

Interviewing

As I sought to gain rich insight into queer women's meaning making, practical negotiation, and experiences of sexuality and sexual health, qualitative interviewing was the most appropriate means of gathering this kind of data (see Ezzy 2010; Rubin and Rubin 1995). Following a queer feminist methodological approach, I was highly anticipating the valuable opportunity to talk to women about their personal experiences of sexuality and sexual health and to allow their stories to "speak" through my research. This was integral as I was working with methodologies that call for research methods that allow the voices of women and LGBTIQ people to be heard authentically through the project (see Oakley 1981; Kong et al. 2001).

Interviews with women lasted for up to two hours and were held in mutually convenient public places such as cafes, the university campus, and an art studio. I developed an interview schedule to help guide the trajectory of the interviews

(See Appendix I). The development of the interview schedule was informed by the literature reviewed in Chapter 1. The themes discussed reflect the overall research questions: identity and labelling sexuality, understandings of safe sex and risk, experiences accessing sexual healthcare in general practice settings. When devising the specific interview questions, I modelled my questions on those of Power et al. (2009), Bourne and Robson (2009), Senior et al. (2014), Burkett and Hamilton (2012), and Bishop (2013).

Employing feminist interviewing techniques (for an overview, see Hesse-Biber 2007; Reinharz 1992), I designed the interview schedule with a semi-structured format to allow participants to introduce topics of importance to them (see Goldberg et al. 2009; Moustakas 1994; Van Manen 1997). I asked open-ended questions and the order of questions varied. Some questions were phrased differently depending on the context of the interview. Participants also asked questions. This was important because researcher self-disclosure is a means of promoting equity in the interview relationship (see Oakley 1981: 49). Many feminist researchers find answering personal questions and offering feedback in this manner is helpful in establishing rapport (see Oakley 1981; Reinharz 1992). Prior to each interview I annotated the guide with some specific questions to ask participants. For instance, if they identified a certain way I included questions about that identity. These revisions/additions helped me to develop the guide for subsequent interviews.

Like many queer feminist researchers (see Browne 2003; Taylor 2011), I established a friendly, conversational tone in the interviews, encouraging the participants to see me as a knowledgeable but sympathetic ear rather than strictly a researcher. This process was noticeable when the participant and I were already acquaintances or we had a number of mutual friends. I designed and conducted the interviews, and the research as a whole, "in such a way that women obtained immediate short term benefits from being interviewed" (Kitzinger 1987: 75). At many points, I was reminded of Birch and Miller's (2000) discussion of the interview as therapeutic, in which they consider the fine line between qualitative interviewing and counselling or therapy. Like Birch and

Miller (2000: 190), often what I considered to be "good" data or a successful interview was when participants shared stories or reflections that were deeply personal, thoughts or feelings that they had never articulated out loud before. A number of participants cried or were on the verge of tears in interviews. Yet in many cases the "interview as therapeutic" went both ways as I learned about myself through the process of interviewing and sharing stories with participants, highlighting the sense of "communion" felt in a number of my interviews (Ezzy 2010: 164).

Ensuring ethical conduct in interviews was paramount, especially when participants were vulnerable. During the interviews, consent was an ongoing process. I checked in with participants at various points throughout to reiterate and renegotiate the ethical boundaries of the interview. I encouraged participants to only discuss topics or events that they were comfortable sharing and reminded them that they could withdraw at any time. When participants shared challenging, emotional memories (e.g. experiences of homophobia, abuse, unsafe sex) I always acknowledged that what they had told me was deeply personal and thanked them for sharing those experiences with me. Following the interviews, participants were invited to discuss how they felt about the process and if they had any concerns as a result of participating in the research. The research information sheet (see Appendix C) contained details referring participants to support services, should they require them as a result of their participation in this study. I reminded participants about this information at the end of each interview. After challenging interviews it was also important for me to engage in peer debriefing as a researcher protection strategy and to prioritise transparent and ethical research conduct. Debriefing with my supervisors and colleagues allowed me to discuss any ethical or legal issues that arose during interviews, interrogate how my personal values and theoretical orientations were influencing data collection and explore early interpretations of the data (see Ezzy 2002: 66-67).

Interviewing Medical Practitioners

To gain another perspective on queer young women's experiences of sexual healthcare in Tasmania, I interviewed six general health practitioners in Southern Tasmania. While I used a similar interviewing technique as with the young people, I purposely designed the interview guide (see Appendix J) for practitioners to be shorter given their busy schedules. Interviews only lasted up to thirty minutes. These interviews were all conducted in the doctors' consultation rooms. I modelled a guide for these interviews on those devised by Hinchliff et al. (2005) and McNair et al. (2015). Following a grounded theory approach, I also developed interview questions in this guide around issues already discussed in the interviews with women. For example, one question I asked was: "Some of the women I've interviewed have felt that communication barriers impacted their doctor-patient relationships – What is your experience of this?" This allowed me to gain multiple perspectives on themes, issues and concerns raised by the women while also producing research findings grounded in participants' experiences.

Historically, doctors have been positioned as authority figures and experts to be afforded the utmost respect (see Freidson 1970; Turner and Samson 1995). I was nervous about interviewing doctors as I saw them as "experts" compared to my status as a postgraduate student (see also Richards and Emslie 2000). However, it soon became apparent that some of the doctors saw me as more of an expert in this field than them. Although the doctors I interviewed were known as "gay friendly" or interested in LGBTIQ health issues, few really had an in-depth knowledge and familiarity with the area. Therefore some of the doctors related to me as an "expert" – wanting to impress me or seeking my help in improving their consultations with LGBTIQ patients (see also Nash 2012: 20-21). For example, one GP asked me what were the correct gender pronouns she should use for one of her transgender patients, while another wanted to know how to attract more LGBTIQ patients to her private practice. There was often a sense that they saw me as auditing their performance as GPs. One GP had printed out her practice inclusivity policy and had put a small rainbow flag on her desk. On the path to achieving my PhD, and becoming a "doctor" myself, it was an unexpected experience to be seen by medical professionals as an expert, despite

the fact that I had not yet completed my degree.

However, I found it difficult to build rapport with doctors due to these differences in status and disciplinary-specific ontologies and the short timeframe available for interviews. When I informed doctors that I was completing a PhD in sociology, some were dismissive of sociology as a discipline and critical of the rigor of my study. For example, one senior doctor asked if any of my PhD supervisors were based in the medical school and was adamant this was necessary for the success of the study. Another with similar concerns even offered to join my supervision team. Others questioned methodological aspects of the research and were critical of its lack of generalisability. As in Richards and Emslie's (2000: 73) auto-ethnographic account, some doctors apparently saw me more as "the girl from university" rather than an academic researcher or expert. To overcome this, I bridged discipline-specific communication barriers using medical terminology and revealing knowledge about certain specialist areas of LGBTIQ sexual health (see also Hansen 2006: 103). This tactic was successful in convincing sceptical doctors of my competency and it encouraged them to engage in discussion.

Transcription and Analysis

Interviews were audio-recorded and transcribed verbatim with the consent of participants. I also wrote field notes as soon as possible after the interviews so as to retain some of the aspects of the interview that may not have been captured by the recording. In keeping with a reflexive, feminist methodology, I refer to myself in the transcripts as "Ruby," rather than "interviewer" or "researcher" and use pseudonyms chosen by participants to represent them. I also include pauses, tones, non-verbal sounds and other gestures in the transcripts. Depending on the type of pause, these are denoted with ellipses, commas or sometimes "(long pause)." I also found it necessary to represent the animated nature of some of my participants, who often used humorous voices when recounting how someone else had spoken to them. These glimpses into the lifeworld of participants were important to capture. However, this was not an

easy process, as I was aware of my influence as the researcher/author, interpreting and shaping participants' voices in certain subjective ways that the participants themselves might have described differently.

The transcription process became an early stage of data analysis, as I began to identify some early themes through the process of close listening and typing the transcripts (Ezzy 2002: 70). I wrote reflexive memos and field notes often directly following transcribing an interview to capture some of these preliminary analyses. A number of researchers working in the grounded theory tradition discuss the importance of writing such memos (see Corbin and Strauss 2015: 106; Orona 1990: 1250) and this process of capturing my internal dialogue useful for the analysis. While I planned to take some notes during interviews, I found this was detrimental to rapport, distracting for the participant, and impeded the process of close listening. For example, in one early interview, while the participant was talking I looked down to write a note and they stopped abruptly to ask "what are you writing?" and I lost my place, causing us to change the subject.

Transcribing the interviews early and during ongoing data collection was an important part of my development as an interviewer as it forced me to reflect on interviewing techniques. After conducting and transcribing the first few interviews, I became more aware of times when I had cut participants off, not followed up on a potentially meaningful theme, or detracted from the natural flow of the discussion by too rigidly clinging to my interview guide. Although I wanted the interviews to be conversational in tone, in early interviews I sometimes became flustered if I perceived interviews to be "going off track." Rather than employing probing questions to follow the participant's line of thought, I returned to the next question on my guide. In interviews where I did this flow is halted and participants became hyper-aware that this was a "formal" interview, rather than a friendly discussion. Listening back to interviews, I identified this as an issue and improved my technique in subsequent interviews, resulting in richer discussions. These reflections on transcription highlight the iterative process of my data collection and analysis.

As Ezzy (2002: 68) explains, "understanding does not come only from individual researchers locking themselves away and reflecting on their data." I found that discussing my early reflections on the raw data was an integral part of gathering my thoughts around the analysis of my findings. Having informal discussions with colleagues, friends or family members was a process of thinking out loud and crystallising ideas, concepts and theories much like Orona's (1990: 1250) "blue skying" – a free-form articulation of ideas and hunches. Transcription was the first link in the iterative chain of analysis. More than just a transferal of spoken word to text, verbatim transcription immersed me in the data and allowed my findings to "float about" my consciousness, until being absorbed (Orona 1990: 1249).

I conducted the initial first phase of coding and analysis manually, with printed transcripts, written annotations, and colour coding. For the later phases of analysis, and as I conducted more interviews, I used qualitative data analysis software (QDAS) NVivo (version 11.2.2 for Mac) to analyse and store data. Grounded theory involves a systematic, flexible inductive process that focuses on theory building "grounded" in the empirical world (Charmaz 2014). Bringer et al. (2004; 2006) demonstrate that QDAS can be used effectively to facilitate grounded theory analyses (see also Hutchinson et al. 2010: 284). Bernauer et al. (2013: 6) have similarly argued that many of NVivo's functions complement the grounded theory process, or, what they refer to as, the "three 'Cs' of data analysis": coding, categories, and concepts (see also Lichtman 2013). The grounded approach allows for concepts and theory to develop inductively out of the data (Charmaz 2014). Taking this approach, I coded and analysed the interview transcripts in three stages, including: open coding, axial coding, and selective coding (see Corbin and Strauss 2015: 88). As Orona (1990: 1249) observes, this endeavour is not necessarily linear, but an iterative and, at times, chaotic process, which involved me shifting from one coding approach to another and back again.

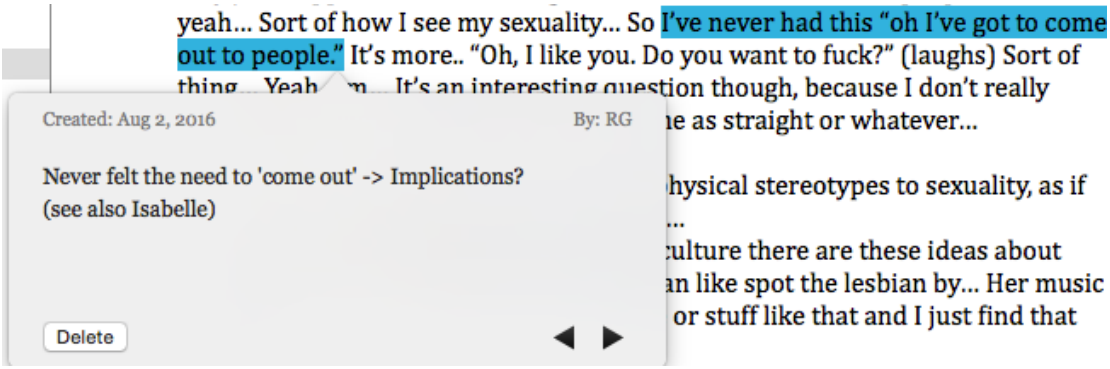

Fig 2.1 Annotating an interview transcript in NVivo.

Open coding began shortly after transcription, preliminary analysis, and memo writing. In this phase, I analysed the printed transcripts line by line, annotating them, taking note of emerging themes and concepts in each interview. Once interview transcripts had been imported into NVivo, I followed the grounded theory approach of surface reading transcripts "line by line," noting any striking words or phrases to arise from the data using NVivo's annotate function (see Fig 2.1). Glaser (1978: 56) describes this process as a way to "generate an emergent set of categories and their properties," or, as Stauss and Corbin (1990: 62) put it "naming and categorising phenomena through close examination of data." Once I identified common themes in the interviews, I created a "node," or category, for them and coded relevant data to those nodes. Node systems allow the researcher to store data under categories for retrieval and analysis (see Richards 1999: 56) and foster the concept building that constitutes "the guts" of the grounded theory approach (Orona 1990: 1249).

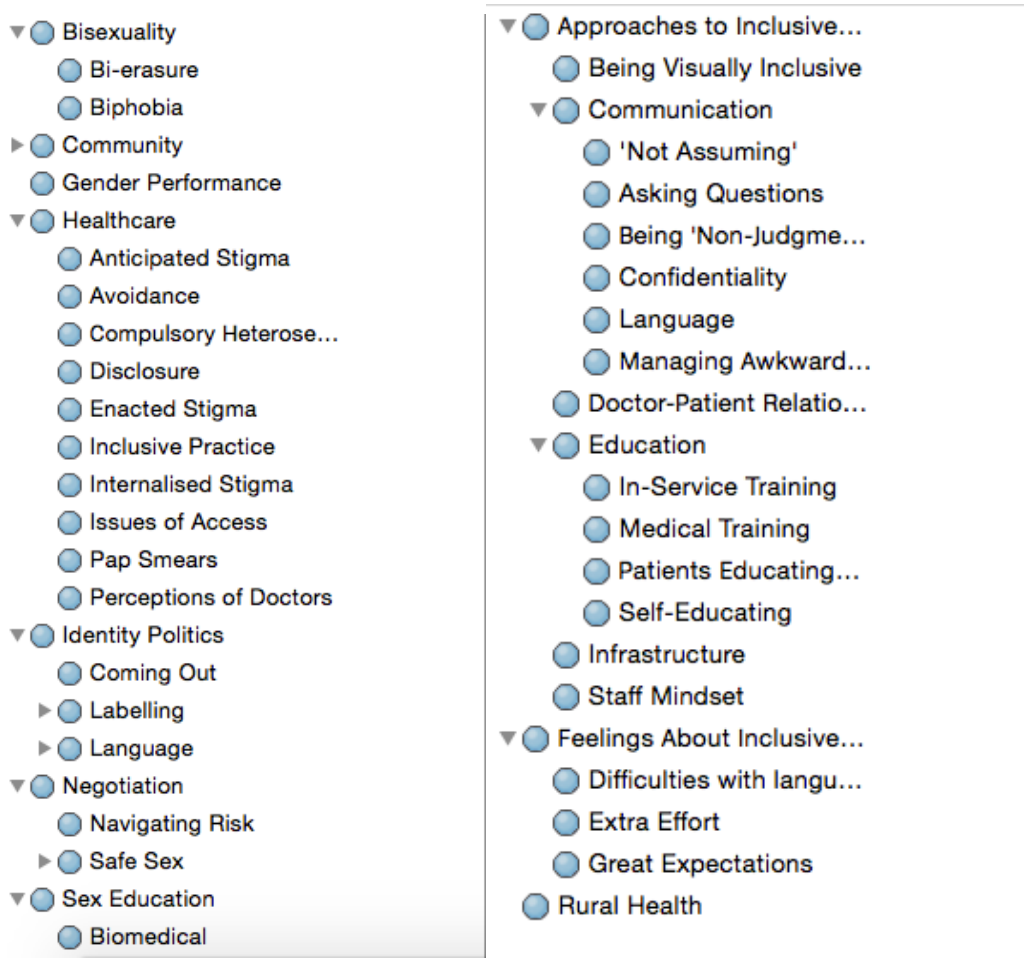

Fig 2.2 Entire NVivo Node system – Women; Fig 2.3 Entire NVivo Node system – Practitioners.

To begin, I created nodes based on the overall themes arising from the interviews (e.g. "bisexuality," "healthcare," "negotiation," "identity politics"). Through a process of descriptive, open coding, I then coded any examples participants gave into the appropriate node. Data coded under these nodes was then grouped into subsidiary or "child" nodes to describe specific aspects of what participants where discussing. For example, some initial child nodes that emerged under the "parent," or larger, node for "bisexuality" were "bi-erasure," "biphobia" (see Fig 2.2). Nodes were developed either descriptively, using my own labelling and categorisation of the themes (e.g. "Compulsory Heterosexuality") or "in-vivo" (see Bringer et al. 2006: 252), by using participants' direct wording (e.g. "being non-judgmental") (see Fig 2.2-2.3).

Developing the node system was an iterative process. As I shifted towards more

interpretive, axial and selective coding, I identified new ways to re-structure the nodes and build meaning from the findings. Once I analysed and coded more transcripts, I employed grounded theory techniques of "axial coding" and "constant comparison" to draw similarities and differences in themes across the entire data set (Corbin and Strauss 2015: 89). As part of this process I often sorted transcripts into "chunks" of text, looking for key themes, underlining striking or interesting statements, and employing theoretical questions about the meaning and message behind what was being said (Corbin and Strauss 2015: 89). Through this process, many initial nodes or themes arising in multiple interviews grew into larger, more abstract nodes. For example, having coded descriptively, I originally had separate nodes for "language," "being non-judgmental," and "asking questions" (see Fig 2.3). Upon further reflection, I identified "communication" as the broader theme, so I created a new parent node for them all to be housed under (see Fig 2.3). Sometimes it was only at the stage of having analysed a number of transcripts that codes became evident. Here, the NVivo node structure facilitated the development of grounded theory, as it allowed me to "create analytical codes and categories from the data itself" (Hutchinson et al. 2010: 284), which could then be abstracted to a higher level (see Orona 1990: 1249). Once I had generated new nodes, I re-read transcripts with these in mind in the final coding process of selective coding.

Reflexivity and Standpoint

Limitations

The significance and strengths of this research are highlighted throughout the thesis. However, as a reflexive researcher it is important to consider the limitations of the project. According to Ezzy (2002: 81) "qualitative research is demonstrably trustworthy and rigorous when the researcher demonstrates that he or she has worked to understand the situated nature of participants' interpretations and meanings." The purpose of qualitative research, then, is to develop empirically informed theories that can be used to understand individuals' meaning-making experiences. With this in mind, qualitative research

cannot make claim to the broader, generalisable conclusions of some quantitative approaches. As I have discussed, snowball-sampling strategies produced a relatively homogenous sample of young women who were mostly urban, white, middle-class and highly educated. It is important to recognise how intersecting privileges of whiteness and class shape the findings of this study and to acknowledge that these stories are specific to these participants' experiences and not the LGBTIQ community as a whole. This is limitation of this study as LGBTIQ health research and queer theory have largely focused on white, urban perspectives, and LGBTIQ young people from culturally and linguistically diverse backgrounds, low socio-economic status and, rural areas stand to benefit the most from empirically-driven social supports and policy. Therefore, ongoing further research is needed to focus specifically on these intersecting experiences of LGBTIQ young people in Australia.

The sample size of six interviews with practitioners is small, meaning that any claims to representativeness and generalisability are unlikely, although not the purpose of this study. In future work, a more systematic approach to connecting with the medical community and gaining organisational support leading to possibilities for third party recruitment would likely generate a larger sample. As Hinchliff et al. (2005: 352) similarly identified, the use of face-to-face semi-structured interviews for this portion of the study may have produced less reliable findings, as the GPs that did participate were unlikely to report negative or homophobic attitudes in person due to the impact of social desirability. Furthermore, given that GPs identified busy work schedules as a challenge to prioritising inclusive practice, it is also likely that the perceived time commitment of a face-to-face interview deterred other practitioners from selecting into the study, especially if LGBTIQ health was not already an area of interest to them. While it is important to recognise these limitations, this aspect of the study was primarily designed to supplement the data from interviews with women. The data presented here is intended to be exploratory and pilot pathways for future research. Despite its limitations, as I will discuss in Chapter 6, the findings from this part of the study importantly provide a "snapshot" of Tasmanian practitioners' approaches to LGBTIQ-inclusive practice and identify

the need for additional research to inform professional supports for rural GPs.

Researcher Identity and Standpoint

An important facet of intersectional feminist and queer research methodologies is to acknowledge the role played by the researcher in the research process. Placing disempowered groups in the traditionally passive position of the "researched" often works to perpetuate their othering from dominant cultures. This has been the case with women and LGBTIQ communities (see Kitzinger 1987: 66; Kong et al. 2001). Challenging these power differentials in social research from a queer feminist and intersectional perspective is achieved by acknowledging and considering researcher standpoint through ethical project design.

For Davis (2014: 28) one way to practically incorporate intersectionality into feminist research methodologies is to critically engage with one's own "multiple positionings as a researcher in terms of gender, class, ethnic, sexual, and other social identities." For intersectional feminist scholars, locating oneself at the outset of inquiries aims to avoid what Haraway (1988) refers to as "the god-trick" – or "the conquering gaze from nowhere." Following Gamson's (2000: 359) suggestion that in queer research, "the researcher's authoritative voice is increasingly positioned as one among many competing, partial voices - none, and all of them 'authentic,'" I thought reflexively about my self-presentation and standpoint as the researcher and author of this thesis. In particular, I questioned what it meant for me to be conducting this research as a young, white, middle-class feminist academic who identifies as bisexual but is in a long-term relationship with a man. I was initially concerned that potential participants would not wish to engage with me if they were unsure about my sexuality or perceived me to be heterosexual. These methodological concerns intersected with personal anxieties, often experienced by bisexuals, about not being "queer enough" to occupy queer spaces (see McLean 2008; Wandrey et al. 2015). Feminist approaches emphasise researcher self-disclosure as valuable in challenging consciously decided to discuss my identities with participants (see

fig 2.4) (Reinharz 1992: 32-33; see also McDonald 2013). Despite my initial hesitancy, having only "come out" at the beginning of my PhD, participants were empathetic and my own self-disclosure often prompted participants to share their own experiences. Through this process, like McDonald (2016: 11), the more I learned about queer theories and their anti-categorical approach to difference and identity, the more confident I became in moving beyond these false and contradictory notions of what it meant to be "authentically queer."

Fig 2.4 Researcher self-disclosure online

In contrast to positivist methodologies, feminist researchers often emphasise the advantages of conducting "intimate insider" research among groups of which the researcher is a member (Taylor 2011). Oakley (1981: 55) believes that power imbalances and other ethical issues are more likely to occur when there is significant difference in status between researcher and the researched, with shared experiences of membership in an oppressed group creating a more equitable researcher-researched dynamic. For many researchers, being an insider to particular communities and subcultures has had a number of advantages in terms of accessing participants and achieving trust and rapport through shared experiences and understandings (see Browne 2003; Brown-Saracino 2014; Hodkinson 2005; Taylor 2011).

Acknowledging researcher standpoint can be especially important in queer research, as Kong et al. (2001: 251) explain:

> Gay interviewing often brings with it a kind of gay and lesbian sensibility that informs the questions asked, the types of relationships formed, and our ways of knowing. For some researchers, this finely tuned aesthetic facilitates the process of building a collaborative, communicative experience between interviewer and interviewee, and it suggests the need for a greater ethical awareness of this relationship. Thus many gay men, lesbians, and bisexual and transgender people will speak about their personal experiences only when they feel safe.

LaSala (2003: 18) similarly observes that research participants who are members of oppressed minorities may be more trusting of researchers to accurately portray their lives and strive for social justice for their group if the researchers are also members. This has been the case for a number of insider LGBTIQ researchers, for example, when Kitzinger (1987: 74) disclosed her lesbian identity to her UK participants, many said they would not have participated if she did not share their identity. Similarly, in Brown-Saracino's (2014) ethnography of lesbian and queer women's community participation in North American small towns, disclosure of her shared identity as "non-heterosexual" was essential for her recruitment, entrance and participation in local gay and lesbian social scenes in each town. Because of their shared membership in the lesbian and queer subculture, participants eagerly invited Brown-Saracino (2014) along to their social gatherings where she was able to conduct ethnographic observation and recruit participants for interviewing.

It is not uncommon in queer research for researchers to intentionally blur traditional boundaries around what is "appropriate" in research relationships (Kong et al. 2001: 251). In studies of queer social scenes, researchers have often recruited and studied from within their own personal friendship circles (see Browne 2003; Esterberg 1997; Taylor 2011). This is taken further in accounts of

research where sexual encounters may have or did occur during fieldwork (see Bain and Nash 2006; Hammers 2006; Lambeviski 1999; Newton 1993). In such studies researchers can often make use of auto-ethnographic data resulting from thinking self-reflexively as an insider in the field. While I was amenable to forming friendships through research as part of feminist interviewing, like Browne (2003: 141) my feminist methodological identity made me wary of potentially exploiting individuals for research purposes.

In the spirit of feminist research practice, I intentionally conducted this research with a sense that interviews were to be more like "conversations with a friend" (Browne 2003: 139-140; see also Hesse-Biber 2007). Fostering this sense of reciprocity emphasised the non-hierarchical approach to power dynamics in the interviews with young people. Participants often perceived their role in the research as "helping out" with my study, but in return, as with Brown-Saracino (2014), many invited me to attend theatre productions or local queer and feminist events. While a traditional approach to research discourages accepting these kinds of offers (see LaSala 2003), like Kanuha (2000), accepting these offers was often necessary for maintaining rapport and ongoing reciprocity. Establishing and maintaining an identity as an ethical researcher was also necessary given the close-knit Tasmanian LGBTIQ community where fostering reciprocity would have important implications for future research, as well as professional and social ties with the community. Therefore, by attending these events and continuing my relationship with some participants after their interviews, I felt that I propagated reciprocal relationships with participants and their communities.

It is necessary to consider the complexities of being both an insider, as a member of the group being studied, and an "insider-outsider" while acting as a researcher in the group. Although many scholars have made a case for the benefits of being a research insider, shared identity does not necessarily always ensure research success (see Kitzinger 1987: 66). This was especially the case in Brown-Saracino's (2014) recruitment attempts in one ethnographic site in her US study, where, despite using similar sampling techniques as in other sites, the local

lesbian community were extremely hesitant to engage. Although Brown-Saracino was a lesbian insider, potential participants saw her as a geographical "outsider" and this may have affected recruitment (2014: 58). This was also the case in my research, where I faced recruitment difficulties in the rural North of Tasmania and in accessing medical practitioners who were willing to discuss LGBTIQ issues.

Similarly, for Kitzinger (1987: 88), sharing an identity as a lesbian did not guarantee that potential participants would be amenable to interacting with her, as she reflects that "my own obvious whiteness and middle-class-ness severely limited the extent to which I could be perceived as an 'insider' by some women." This reflects a key criticism of the works of feminists like Oakley (1981) who claim that the relationship between women interviewing women is inherently non-hierarchical, as these fail to account for important differences among women, such as class and race. Taking a queer, intersectional approach, the assumption that shared group membership will allow for a positive research relationship is problematic, as all people have "multiple identifications," as Kitzinger's (1987) recruitment attempts demonstrate (Twine 2000: 15). McDonald (2013: 130) argues that insider/outsider arguments often assume harmony and equality within particular groups, which is seldom the case in actuality.

As a straight researcher who is critical of heteronormativity and binary identities, Allen (2010) considers the place of researchers, like herself, who are "straight with a twist" in queer projects. The involvement of "straight queers" in queer theorising has been highly contested, with some arguing that heterosexual inclusion in a "non-heterosexual" movement is problematic (see Schlichter 2004). Drawing from queer theoretical perspectives on the fluidity of identity and knowledge (see Butler 1991; Fuss 1991; Sedgwick 1990), Allen (2010: 161) challenges notions that sexual identity contributes to the knowledge one produces, arguing that as a hegemonic system heteronormativity can just as equally impact non-heterosexual researchers' world views and knowledge production. Thus, according to Allen (2010: 161), queer thinkers can produce

(hetero)normative knowledge, just as straight researchers can produce queer knowledge. Through a process of thinking reflexively while conducting queer feminist research on sexuality, like Bain and Nash (2006: 105), designing this research raised some "awkward questions" for me about whether I could or should explore alternative self-understandings around my own sexual identity.

In some cases, being an "outsider" in sexuality research may act as an advantage, as participants may be more willing to share intimate information with someone they do not have an enduring association with (see Allen 2010: 150-151; Levy and Johnson 2011: 138). For example, in Levy and Reeves' (2011) study of gay, lesbian and queer young people with a Christian upbringing, Levy considered her standpoint and discussed how she mediated difference and sameness in the research relationship for positive outcomes:

> As a straight woman studying queer individuals with a Christian upbringing, the first author found participants to be open, friendly, and interested in her research. This could be because, during the pre-screening interview, she disclosed her own identity, explained why she was interested in this line of research, let individuals know that they could discontinue participation at any time, discussed the process of member checks, and genuinely and warmly expressed her appreciation for participants' willingness to talk with her. (Levy and Johnson 2011: 138).

As Kong et al. (2001: 252) similarly emphasise, regardless of difference or sameness in the researcher-participant relationship, a key aspect of conducting ethical queer research in LGBTIQ communities is to prioritise reflexivity, sensitivity and integrity throughout the research process.

Applying a queer theoretical perspective to discussions of researcher identity and standpoint raises questions in these detachment-involvement debates. McDonald's (2013; 2016) notion of "queer reflexivity" resonated with my approach to this thesis. For McDonald (2013: 128), there has been insufficient

consideration of the extent to which the identities of researchers and their participants, and the meanings they attach to these identities, are subject to transformation during the research process. McDonald (2016) encourages us to think reflexively about the concept of the closet (see also Sedgwick 1990), considering the multiple ways in which we construct, conceal and disclose aspects of our identities during qualitative research. Because queer theoretical approaches encourage researchers to view identities as multiple, fluid and contextual, McDonald's (2013, 2016) work is significant in that it challenges the binary nature of detachment-involvement debates, encouraging us to employ a queer reflexivity to question the ways in which researcher and participant identities are constructed and reconstructed throughout the research process. However, while McDonald's account of shifting researcher identity is useful, I found that it still reflects the very linear meta-narrative of the classic coming out tale (see Plummer 1995; Sedgwick 1990). His identity negotiation culminates neatly at the end of his research - a progression from embodying "straightness" at the beginning and "gayness" at the end (2013: 128). Moreover, McDonald's (2013) approach does not engage with intersectionality, neglecting to interrogate how his sexuality and coming out process is mediated by his gender, race, or class status.

In the process of acknowledging my methodological identity and researcher standpoint, I drew on Kong et al.'s (2001: 252) directive that it is important for "researchers [to] begin by first constructing ethical identities in the communities they wish to study, so that individuals, groups, and networks in those communities begin to see the researchers as trusted insiders (or trusted outsiders, as the case might be) who are not out to misrepresent them in their research write-ups." In light of my position as an "insider" and "outsider", I prioritised a reflexive, ethical approach to this research. By considering queer researcher identity and detachment-involvement debates, I suggest that when we are reflexive and open with participants about our own shifting, uncertain or multiple identities, we can garner a deeper reciprocity in the project of meaning-making (see Ezzy 2010: 2).

Chapter 3: Identity

Introduction

As discussed in Chapter 2, I initially had a limited view of how potential participants might articulate identity, assuming most would describe themselves as lesbians. Instead, my participants identify with a range of queer sexualities that challenge this simplistic view. In this chapter, I explore how the women I interviewed make sense of queer identity and sexual citizenship. Drawing on the theoretical discussion of neoliberalism, queer identity politics, and intersectionality in Chapter 1, this chapter examines how the women position themselves in these debates. Identity and sexual self-labelling was a key theme that arose inductively during interviews, with participants eager to share stories of how they understand and articulate their sexual identities. Therefore, I begin my discussion of the research findings with an exploration of identity construction, as this was often what began our conversations in the interviews, but also because the ways in which queer young women articulate identity have important implications for how they access healthcare.

In larger scale studies of LGBTIQ health, bisexual and queer women report poorer health and wellbeing than other groups, however the reasons for this are not well understood. I suggest that a greater understanding of bisexual and queer women's identities and intra-group politics may shed light on these sexual health issues, which I will explore in detail in Chapters 4-6. In this chapter I argue that the identity labels participants have adopted reveal their understandings of contemporary queer selfhood. In line with research on queer youth in the US and UK (see Adams et al. 2014; Coleman-Fountain 2014; Ng 2013; Savin-Williams 2005), my participants express frustration with identity politics and labels; nearly all preferring to avoid classification either by rejecting labels entirely or embracing ambiguous terms. Therefore, this chapter asks: Are young women resisting sexuality labels because of increased sexual fluidity, or as an attempt to claim ordinariness? Is distancing oneself from labels radical? Or is it a depoliticised act of privileged complacency?

As outlined in Chapter 1, scholars from a range of disciplines observe that, due to growing acceptance of sexual minorities in the West, LGBTIQ young people are defining themselves less in terms of their sexuality and are increasingly questioning and resisting traditional identity labels, experiencing gender and sexuality in fluid, more nuanced ways (see Adams et al. 2014; Coleman-Fountain 2014; Hegna 2007). Richardson (2005: 516) argues that these contemporary LGBTIQ movements are increasingly deploying a "neoliberal politics of normalisation" that emphasises gay and lesbian "ordinariness" in order to campaign on the grounds of equality and the rights of individuals rather than collective "gay rights." Ghaziani (2011) documents a similar shift in language among US college LGBTIQ groups, with liberation rhetoric (e.g. "gay and lesbian rights," "gay marriage") being replaced by assimilationist language (e.g. "rainbow," "pride," "marriage equality"). In this context, individuals are arguably moving away from collective identity labels and are constructing their own highly specific identities (Halberstam 2005; Stein 2010). Ghaziani (2011: 100) claims that this "escalated internal diversification" of what were previously merely "gay and lesbian" movements, is characteristic of the neoliberal "post-gay" shift, with identities becoming increasingly fluid and difficult to define, resulting in the "alphabet soup" of the continually expanding "LGBTIQ" acronym.

Drawing on Muñoz's (1999: 11) use of the Pecheuxian paradigm of identity, this chapter is structured in three parts. The first part considers participants' experiences of identification with sexual identity labels. I argue that labels provide an important framework for some participants to construct their identities and gain validation from others. In the second part of this chapter, I consider other participants' "counter-identifications," or rejection of traditional and static identity labels, arguing that the departures these women make reflect post-feminist and post-gay "neoliberal politics of normalisation" (Richardson 2005: 516; see also Duggan 2002, 2012). Here, although participants' deploy queerness, I will show how their framings of identity are less illustrative of post-structural "critical revisions" of identity (see Hegna 2007) and moreso exemplify the post-modern neoliberal self as project (see Giddens 1991). I also suggest that

the post-feminist de-politicising of gender and sexuality shapes queer young women's turn to homonormativity. However, in the final part of this chapter, I argue that participants do not always abandon labels entirely, but deploy them reflexively. In discussing bisexuality, the women make intriguing departures from their neoliberal politics, indicating attempts to carve out new space beyond the post-feminist/post-gay ideologies they have internalised. Therefore, to conclude, I argue that these departures are examples of Muñoz's (1999: 11) disidentification - the participants working "on, with, and against" dominant identities and narratives of queerness.

Identification

> If I say "tree" you might picture a palm tree and somebody else might picture an oak tree and that's fine [...] but, like, we would all agree that a tree is a plant and it has roots, they go down in the ground, it takes up water, chlorophyll, whatever, some kind of leaves or pine needles, brown and green, and so there's a general framework that everybody understands […] There's variations on it, but we know what it means. (Tabatabai 2010: 571-572).

In the quote above, Tabatabai's (2010) participant describes how labels provide a workable "framework" to communicate abstract ideas, experiences, and identities in a way that, despite being open to interpretation, can easily be understood by others. For this reason, sexual identity labels have been instrumental in establishing LGBTIQ communities and mobilising for collective rights (see D'Emilio 1983; Rubin 1986). However, as I discussed in Chapter 1, there have been ongoing debates within these communities around the political utility of sexual identity categories. While traditional gay and lesbian rights movements operated under an essentialist politic, with a basis in the notion of a fixed and innate gay or lesbian self, queer approaches take a deconstructionist stance, viewing identity as fluid and unstable (for an overview of these debates see Seidman 1997). The "ethnic" model emphasises the importance of assimilation with mainstream heteronormative society, viewing sexual identity

categories like ethnic minority groups - vital for collective identity and political mobilisation for rights (Duggan 2012). Conversely, queer perspectives position strict identity categories as reductionist norms constructed by oppressive, dichotomous, and hierarchical systems (Jagose 1996). Muñoz (1999: 5-6) challenges the dualism of these explanations of identity as either essentialist or constructed, claiming that the realities of identity formation differ among individuals and involve a combination of fixed and developed attributes. Muñoz's (1999: 6) important contribution to these debates is his notion of "disidentification," a process where new subject positions form "at the point where the discourses of essentialism and constructivism short-circuit." In this section, I consider how my participants' made sense of identification, beginning with a discussion of identity labels.

Laplanche and Pontalis (cited in Muñoz 1999: 7) define identification as "a psychological process whereby the subject assimilates an aspect, property or attribute of the other and is transformed, wholly or partially, after the model the other provides." In the tradition of symbolic interactionism, Esterberg (1996) positions this process as a form of reflexive "identity work" where individuals actively craft and then name their public and private sexual selves (see also Hekman 2004). The women I spoke to embody this identity work through their negotiations of sexual identity labels. Participants recognise that there are set conventions for how to articulate non-normative identities in a way that will be intelligible to others, chief among these being "coming out" and claiming an identity label. In keeping with these "coming out" meta-narratives (see Plummer 1995; Sedgwick 1990; Weeks 2003), interviews often began with participants recounting their initial realisations and adoption of certain identity labels. For example:

> It didn't just dawn on me one day. It had always been there, it was only when I… Put it into words in my head, I suppose. Realised that it was a thing… (Miki, 25, bisexual).

> My friends had been going on about it [pansexuality] for a while and

> that's when I kind of.. um.. realised that it was a thing.. yeah.. (Jayden, 20, pansexual)

> I didn't know there was a word for it. Obviously like.. in 1995, I don't think anyone really threw the word around much. Um but… I definitely knew that I was attracted to… kinda everyone (laughs) Then, in high school, one of my friends came out as bi[sexual] and I was like 'Oh my gosh, yes!' It's a thing! That's totally me as well! (Jess, 25, bisexual).

For some participants, finding out that their same sex attraction was "A Thing," or a communicable, legitimate phenomenon was reassuring. These participants' common use of the word "thing" when referring to their sexuality and desire evokes a sense of ambiguity, of something they could not quite articulate yet, demonstrating their positioning as having identities in flux. However, in the quotes above, it is through claiming a label that participants are able to make sense of their non-normative experiences and form identities. Here, participants' experiences of discovering the words to name their identities reflect the Pecheuxian paradigm of the "good subject" (see Muñoz 1999: 11). Muñoz (1999: 11) describes the "good subject" as one who "chooses the path of identification with discursive and ideological forms," which, in this case, can be understood as the unambiguous claiming of a static identity label (e.g. gay, lesbian, bisexual).

Some participants' accounts of how they came to adopt certain identity labels echo essentialist sentiments. For example, Miki states that her same-sex attraction "didn't just dawn on me one day. It had always been there." In these accounts participants interpret (or reinterpret) their lives in order to support their sense that they were essentially queer "all along," remembering childhood gender non-conformity as an early sign of the 'truth' to their self prior to realising it was "A Thing" (Kitzinger 1987: 110; see also Dempsey et al 2001; Esterberg 1997; Levitt and Horne 2002). However, participant accounts of discovering queer identity labels predominantly occur through interaction with others. This reflects Butler's (2005) observation that identity is already interrupted by the "Other" and is embedded in social structures. From this

perspective, the process of coming out is less of a realisation of essential truth than a process of identity construction and a discursive ordering of subjective reality (see Plummer 1995; Weeks 2003). Once participants discovered language with which to articulate their experiences, desires, and sense of self (realising it is "A Thing"), they were able to make sense of who they are and where they fit in relation to others.

Articulating queerness with identity labels and having these recognised and understood is important for most participants' self-acceptance, sense of belonging, and broader recognition:

> For me, the labels that I've given myself, they're to find other people like me and to explain… in as little words as possible… who I am. Rather than… um... spend time going 'well, is this it? Is this it? I don't know!' Um. Whereas, if I can just go, 'oh, well, I'm *This*' that's fine. That's a lot simpler. (Harley, 19, asexual)

> [Labeling] can be a way of finding some security in yourself.. yeah.. to sort of to be able to... find a label for yourself.. can be as comforting as to deny the labels that other people give you. I think. (Evie, 26, pansexual)

> I think everyone likes to have a name, or a label for it, so they feel, like, normal and things. Otherwise it's a bit hard, you know? (Middy, 19, fluid)

For these participants, the most important function of identity labels is to make sense of and articulate identity to themselves and to others – a bridging of their personal and public identities. For Hekman (2004: 7) "our personal identity makes us different from everyone else. Our public identity identifies us as the same as particular others." Similarly, as Robinson (2013: 23) outlines, "identities bond people together, identify insiders and outsiders, enable political action on behalf of the group, and frame concepts such as disclosure, outing or community belonging." From these perspectives, the labels participants chose can be seen as their "public identities" that communicate selfhood and connect them to others,

while their internal understandings and negotiations of these labels make up their "personal identities." Here, claiming a label is positioned as an "empowered" choice, allowing young women to be reflexive and to articulate their identity and experiences "in as little words as possible," rather than being unintelligible and silent ("Rather than spend time going 'well, is this it? Is this it? I don't know!'"). Claiming a sexual identity label is important to these women who previously had difficulty articulating their experiences. In other words, labeling is a way of "categorising to produce identity" (Coleman-Fountain 2014: 807; see also Hegna 2007). Therefore, identity labels can provide ontological security, and also serve as an important means of articulating non-normative and potentially unintelligible experiences to others.

Some participants experienced situations where their identities were seen as "not a thing." For example:

> Sometimes, it's like.. like it's not really even a thing. It doesn't feel like it's, it's… real.. Like a made up kind of thing... You know, like queer and stuff is kind of like an outer... not really… Some people are really close minded and um… I really don't know how to describe it… (Middy, 19, fluid)

> I feel like honestly… as a bisexual, I'm completely ignored. It's just not even a thing… Like, I think some of my friends… definitely my family.. have completely forgot (laughs) that I once said I was bisexual. Like it was no big deal, but... like… I kind of feel like I'm not counted. So it's um.. yeah.. I still like to use the um label, I guess, to give it a name. To give it a voice. (Stella, 26, bisexual)

> I feel like a bit of an outsider, really… You're like that one… (sighs) You're like the inbetweener and you do feel like… like... no one else really understands… (Miki, 25, bisexual)

In these extracts, references to certain sexualities as being "not a thing" reflect an inability to articulate experiences, making participants' realities invisible,

unintelligible, or trivialised. These accounts demonstrate how heteronormativity marginalises queer sexualities by rendering them unintelligible in dominant systems. Just as participants describe the galvanising process of realising there is a concrete word to define their identities (realising it is "A Thing"), here, participants use the term "thing" to emphasise the invalidation of their ambiguous queer identities. Butler (1991: 20) sheds light on participants' sense of invalidation:

> Oppression works through the production of a domain of unthinkability and unnameability. Lesbianism is not explicitly prohibited in part because it has not even made its way into the thinkable, the imaginable, that grid of cultural intelligibility that regulates the real and the nameable. How, then, to 'be' a lesbian in a political discourse that wages its violence against lesbianism in part by excluding lesbianism from discourse itself?

Although Butler refers to lesbianism here, this quote illustrates how the women's feelings of erasure are mediated by their inability to articulate their identities within established heteronormative and monosexual frameworks. For example, for Middy, identifying as "fluid" places her beyond the "grid of cultural intelligibility," making her feel as though her identity "is like a made up thing." Just as Butler (1991: 20) contemplates how to "be" a lesbian within hegemonic structures that erase lesbian existence (see also Rich 1986), these participants struggle with how to exist as queer women in monosexist, heteronormative systems that demand categorisation.

Therefore, for some, claiming an existing label was an act of rebellion against this "domain of unthinkability," while for others, adopting or creating new words to describe their "unnameable" identities was particularly subversive. For Esterberg (1996: 261), rather than being entirely fluid, "we make and remake our identities […] within the boundaries of convention, and while we may choose to transgress those boundaries, we do so at the risk of making our performances unintelligible." Thus in order to articulate their complex subject positions, participants often actively engaged in identity work - discovering or creating

custom labels to voice their identities, in the perceived absence of traditional labels that "fit" (see Hegna 2007). Subsequently, most participants had actively researched how best to articulate their identities, trying to find words that describe who they are:

> Once I realised it was a thing… I started looking at the different labels. I did a bit of research, but I'm still not 100 per cent sure where I fit… (Jayden, 20, pansexual)

> I swung back and forth between a whole lot of different words and definitions, I think I'm either bi[sexual] or pan[sexual] but it's still not clear cut for me. (Audrey, 20, bisexual)

> I've been looking into a bunch of different labels and stuff and I don't know which one I fit into just yet, which is cool, maybe I'll go on a spiritual journey one day and figure it all out, or maybe I won't… (Jess, 25, bisexual)

These participants share a reflexive process of searching for the right words to articulate their identities, or trying on different labels to see if they fit, a process characteristic of the post-modern reflexive self as project (Giddens 1991). However, despite acknowledging the importance of labels, these participants all feel that none of the existing labels entirely encapsulate who they are. Butler (2005: 21) similarly observes that "the very terms by which we give an account, by which we make ourselves intelligible to ourselves and others, are not of our own making." In stating that "maybe I'll go on a spiritual journey one day and figure it all out," Jess refers to the coming out meta-narrative (see Plummer 1995; Sedgwick 1990; Weeks 2003) where discovery or realisation of one's "authentic" sexual selfhood emerges from a process of deep introspection, followed by the claiming of a static identity. Jess' imagined future "spiritual journey" also reflects Muñoz's (2009) notion of "queer futurity" - a demonstration of queer's post-structural ability to exist beyond the present, stretching out into utopian future possibilities. However, by embracing the

potential of not "figuring it all out" and finding the right label, these participants reflect the post-modern queer self as a fluid, on-going project and they potentially challenge the salience of sexuality as an identity category.

These experiences of navigating and claiming more ambiguous queer identities illustrates what Gamson (1995) refers to as the queer dilemma. The dilemma is that while the purpose of queer is to deconstruct identity categories, in order to do this, one must recognise that categories exist, which confirms them. For example, although some participants reject traditional identity labels, they all still label their sexuality in some way. Gamson (1995: 401) argues that "clear identity categories are both necessary and dangerous," suggesting that although sexual identity labels are important for political mobilisation for rights they can also be restrictive. However Gamson (1995: 400) further observes "deconstructive strategies remain quite deaf and blind to the very concrete and violent institutional forms to which the most logical answer is resistance in and through a particular identity." Similarly, Muñoz (1999: 5) argues that "at times, resistance needs to be pronounced and direct."

Therefore, while some participants embrace terms to articulate ambiguity and individual specificity (e.g. "queer," "fluid," "panromantic," "pansexual"), this could come at the expense of establishing intelligible collective identities on which to claim rights (see Phelan 2003; Stein 2010). Although participants are sceptical of traditional identity labels, their critical revisions of labels suggest a continued importance of sexuality as a defining aspect of their identities. As I will discuss later in this chapter, this invokes Muñoz's (1999: 11) notion of disidentification. Participants neither entirely assimilate within dominant structures of identification nor do they all strictly oppose them. As I have argued in this section, claiming identities provides ontological security and a potential source of resistance for these women. In the following section, I explore the experiences of participants who engage in what Muñoz (1999: 11) refers to as "counter-identification," or the rejection of the symbolic system of identity labels.

Counter-identification

In the previous section, I examined how participants made sense of identity, arguing that claiming a label is important for the majority of participants, even those who embrace ambiguous, customised terms like "pansexual" and "fluid." These experiences of labelling are often situated in ethnic model approaches to identity politics, as participants draw on essentialist notions of an innate sense of "always knowing" they were queer, with labels serving to solidify and articulate their identities to others and build community. However, not all participants consistently take this stance. In this section, I consider the experiences of those participants who choose to reject static identity categories in favour of fluidity and label-less individuality. Muñoz (1999: 11) describes this as "counter-identification," a process where subjects "resist and attempt to reject the images and identificatory sites offered by the dominant ideology." While this resistance to categorisation undeniably draws on queer deconstructionism, I argue that my participants' rejections of labels largely stem from the neoliberal normalising discourses of post-feminism and homonormativity.

Although queer was intended as an anti-category, it has come to be used as shorthand for "lesbian, gay, bisexual, and transgender." The women I interviewed similarly deploy queer as an "umbrella term" that is open to multiple interpretations, allowing them to avoid explicitly defining their identities. Sloane's understanding is particularly illustrative of this approach: "When I say I'm queer… It's… A way of saying… I'm up for anything, or I'm up for most things… Don't assume anything about me. I think that's… what I feel the label should be saying…" For Isabelle, identifying as queer allows her to communicate to others that she is "not straight," without them fully understanding exactly what that involves. She describes this as being "more private." But what, then, is the purpose of rejecting established identity labels only to adopt queer as a new category? What does it really mean to be queer and how can we make sense of such disparate understandings of identity?

Hekman (2004: 4) argues that rather than problematising identification, queer

identity politics has merely "fixed identity in new locations," with new, specific identities becoming just as "fixed and monolithic." For Albury (2015: 645) "sexual identity can only ever be a blunt instrument when one seeks to understand or explain sexual feelings, thoughts and behaviours." Therefore, disillusion with the pressure to use this "blunt instrument", to justify or categorise sexual identity, can explain participants' turn to increasingly specific, ambiguous, and personalised labels like "fluid," "panromantic," and "pansexual." For Muñoz (1999) counter-identification operates in opposition to the totalising ideologies of mainstream identity politics – subjects counter-identify as a way of resisting dominant, exclusionary rhetoric within movements (e.g. gay and lesbian groups). Therefore, in the face of identity politics that even position "queer" as a totalising and restrictive identity, some participants are drawn towards more specific, individualist ways of asserting who they are. As Phelan (2003: 11) outlines:

> Specificity mandates conscious location of the self […] and gestures to that in each of us which is irreducible to categories […] Even after we acknowledge certain categories of difference, there will always be more to us than those categories. We are specific individuals as well as members of multiple groups.

In line with Phelan (2003), participants see themselves as complex, so, for some, identity politics and labels seem to be forcing them to choose only one aspect of their identities (sexuality) as their essential identity over all others, and to articulate this with a homogenising term. Butler (1991: 19) similarly argues that identifying with a category is reductionist, as identities and categories are constantly shifting social constructs, and identifying with a label limits the potential for embracing other identities. However, although some participants' experiences reflect Butler's approach as they reject classification through "counter-identification," in this section I argue that these counter-identifications are not as revolutionary as some may think (see Callis 2014; Stein 2010).

According to Alcoff (1988: 416) "we cannot understand society as a

conglomerate of individual intentions, but, rather, we must understand individual intentions as constructed within a social reality." In light of this perspective, I argue that the young women's rejection of identity labels is characteristic of the neoliberal, post-feminist climate in which they were socialised. Growing up during a time of increasing LGBTIQ equality in the West, for the majority of the participants, their frustration with labels largely stems from a neoliberal perception of ordinariness and a desire to be seen as individuals rather than political or minority stereotypes (see also Adams et al. 2014). For example, Isabelle describes her inner-city upbringing as "very progressive," adding that she has never had to "come out" to her family, "because it's just not a big deal." When I asked about her understanding of her sexuality, Isabelle explained:

> I'm mostly attracted to guys… but I'm also attracted to girls and other genders, so I can't really… I don't know what the specific label is and I kind of can't be bothered finding the specific label. I'm just me. I know I'm not straight. And I guess that's just been… Enough.

Carrie expresses a similar ambivalence when asked about sexuality, explaining:

> I'm a private person. I'm really not into identity politics, or anything like that. It's just not something that really bothers me. Like, I don't think about it at all. (laughs) I just live my life.

Like Isabelle, Carrie has not had an "official coming out event" and cannot remember when or how she first defined her sexuality, preferring to reject identity politics with an appeal to the ordinary: "I just live my life." Both Carrie and Isabelle reflect the neoliberal politics of normalisation in their (re)location of their sexualities as personal or "private", "not a big deal," not a larger part of their public identities. Here, Carrie and Isabelle counter-identify by seeking to establish themselves as individuals who are neither defined by categories nor "bothered" by issues of identity. Cohler and Hammack (2007) refer to this as the "narrative of emancipation," a freeing of oneself from the pressures and

restrictions of labels, in favour of individuality. This phenomenon is characteristic of Duggan's (2002: 179) "new homonormativity." Here, the neoliberal refrain of being an individual who "just lives their life" not "bothered" or restricted by "identity politics" also intersects with Savin-Williams' (2005) notion of the "unremarkable gay," as these participants want to be seen as "ordinary" individuals rather than members of a politicised minority group identity (see also Coleman-Fountain 2014).

In the following section I argue that these complex, and often contradictory, shifts between identification and counter-identification can be explained using Muñoz's (1999) concept of "disidentification."

Disidentification

As outlined in Chapter 1, disidentification describes "the survival strategies the minority subject practices in order to negotiate a phobic majoritarian public sphere that continuously elides or punishes the existence of subjects who do not conform to the phantasm of normative citizenship" (Muñoz 1999: 4). Muñoz (1999: 8) frames disidentification as a response to "normativising protocols" that limit individuals' abilities to identify in certain ways within certain groups. As a result, disidentificatory subjects must work reflexively within these dominant cultural forms – adopting some identities, rejecting some, and reinterpreting others – in order to construct their own identities (Muñoz 1999: 12). In this section I argue that, for my participants, disidentification is both a survival strategy in a neoliberal post-feminist and homonormative society, and an act of resistance within exclusionary, monosexist identity politics.

Sexual identities have largely been constructed around sexual attraction and behaviour. Savin-Williams (2005: 166) describes sexuality as "an individual's enduring sense of self as a sexual being that fits a culturally created category and accounts for one's sexual fantasies, attractions, and behaviour." Sedgwick (1990) also observes that it is widely assumed that self-identification should align with one's public performance of sexual identity, and that this identity is assumed to

be fixed over a lifetime (Albury 2015: 652). However, as I have discussed throughout this chapter, several participants understand and experience identity in ways that do not strictly adhere to these models. Although my recruitment materials invited potential participants who were "same gender attracted," the majority of participants who opted into the study identify as bisexual or pansexual. While the majority of participants (12) have had sexual experiences with multiple genders, three have only had sexual experiences with men. Six participants (3 bisexual, 2 queer, 1 pansexual) were in relationships with men, and nearly all (14) have been in a relationship with a man at some point in the past. It soon became apparent that these participants were seeking a space where they could articulate their complex experiences of queerness that did not necessarily fit with the "normativising protocols," or, accepted narratives and discourses in other queer spaces (see Muñoz 1999: 11). Key concerns included a sense of being "othered" from both LGBTIQ communities and broader society. In light of these experiences, participants engaged in disidentification to at once claim an authentic identity, while also remaining critical of restrictive structures of identification.

Coleman-Fountain (2014: 809) argues that "stereotypes are read into lesbian and gay labels, and deny a person's potential for an authentic identity beyond the caricatures of others." Facing stereotypes and stigma, I argue that participants demonstrate disidentification through the ways they reflexively challenge dominant perceptions of sexual identity. A commonly held perception is the "behavioural standard" for sexuality – the notion that someone is only "authentically" bisexual or queer if they have had equal amounts of sexual experience with both men and women, or a "50:50 split" (see Boyer and Galupo 2015; Flanders and Hatfield 2014; Rupp and Taylor 2010). For example:

> I think… Like, I've actually mostly had cis[gender] male partners I think… Or or more than women… yeah… But then it's like… ridiculous that I have quantified that in my head, oh I've had… I've slept with four women and six men, so I guess like… you know... It's not a numbers game. (Jayden, 20, pansexual).

> I feel like bisexual does have that binary thing, like half of my sexual encounters are with girls and half of them are with guys… And that's really not how my sexual history reads… Because the 'bi' in bisexual has that binary connotation, that suggests like an even 50:50 split, which is why I think people have such a huge issue with it… Like… As a bisexual person, it's like you have to recount your entire sexual history so people can divide it up and see if you are properly bisexual… or properly queer… (Sloane, 26, queer).

> Like, what makes you queer? It's ridiculous! The idea that ... Oh you just have to like sleep with this many women, and like, have this kind of hair cut and (laughing) It's like yeah just get a septum piercing… and then we'll accept you as one of ours. It's not like a coffee card that you get stamped and then they're like "And here is your Queer Card!" like "you are real now!" Yeah it really delegitimises people when we have set expectations for what actually makes someone bi or queer… (Frankie, 25, bisexual)

Participants draw on mathematical imagery to demonstrate what can be interpreted as a sterile and disembodied notion of "quantifying" identity, desire, and sexuality. In these extracts, bisexual and queer women are held to a behavioural standard, causing many women to disidentify with certain labels given the scrutiny they might face in using the terms ("it's like you have to recount your entire sexual history"). However, Frankie's comments demonstrate the futility of policing queerness as an identity that intends to transcend definition and categorisation (Clarke and Turner 2007; Hayfield et al 2013). The use of the coffee card analogy - sexual identity membership as a process of quantifiably proving ones' loyalty - powerfully illustrates participant experiences of the reductive and dehumanising nature of explaining and authenticating bisexuality and queerness for others.

This analogy also illustrates Muñoz's (1999: 8) concept of "normativising

protocols." For Muñoz (1999: 8), the absence of intersectional approaches to difference within minority groups prevents some individuals from accessing collective identities. For Frankie, gate-keeping around who "counts" as queer based on certain experiences constitutes a normativising protocol. This boundary policing leads participants to disidentify particularly with bisexuality, some rejecting the label in favour of "pansexuality." Others continue to identify as "bisexual" in the hope of "transforming a cultural logic from within" (Muñoz 1999: 11). These reflexive engagements are what differentiates disidentification from counter-identification, as rather than rejecting labels entirely in favour of neoliberal individualism, disidentifying subjects respond to biphobia through a critique of labels and attempt to reframe their identities in alternative ways as a result.

Bisexuality among young women is often invalidated as "just a phase" or a means of seeking (male) attention (see Alarie and Gaudet 2013; Boyer and Galupo 2015; Diamond 2003; Fahs 2009). For example, Audrey has been referred to as "a lesbian then, but straight now," since she started dating a man (see also Tabatabai 2010). Others have similarly positioned Francesca's sexuality as provisional: "people ask me like 'oh but you'll probably marry a guy and you'll have kids, right?'" Pip identifies this as a function of hetero-patriarchy: "It just comes back to… every bi[sexual] person is attracted to only men in the end… Like… It's all about men!" Here, just as Butler (1991: 20-21) argues that "compulsory heterosexuality sets itself up as the original, the true, the authentic, the norm that determines the real," these participants' bisexual identities are invalidated by monosexist compulsory heterosexuality that positions women as heterosexual by default (see also Rich 1986).

In addition to facing implicit pressures to quantify their sexual experiences to meet binary definitions of bisexuality, participants also experienced hetero-patriarchal stigma around bisexuality that led them to seek alternative identity labels:

> [Bisexuals are] the slutty girls who are experimenting and just want to have heaps of sex. That's the kind of stigma that I think most people think of. I'm really not keen on that… (Isabelle, 21, Queer)

> I mean… I'm pan[sexual]… I identify as pan now… because I feel I have to.. Cause.. yeah.. because if I say I'm bi[sexual] people just go, "oh but you date guys so…?" There's just a lot of slut-shaming. It's ridiculous! (Francesca, 20, pansexual)

> Yeah I don't say bi anymore cause… I mean… I knew a lot of girls who said they were bi in high school because they wanted guys to like them… There definitely is the vibe that being bisexual is just a synonym for being a slut. (Sloane, 26, queer)

> As soon as you say [that you're bisexual]… No one's ever just like "oh, cool" and carries on the conversation or whatever. It's always like… If you tell a guy then he's like "oh! That's so sexy!" or "Lets have a threesome!" You know…"Send me pictures. Send me video." (Miki, 25, bisexual)

In the extracts above, participants engage in disidentificatory work to dispel the sexualised stigma around bisexuality (see Bower et al 2002; Entrup and Firestein 2007; Fahs 2009; Israel and Mohr 2004; Ochs 1996). Participants' reflexive negotiation of sexual identity labels in response to this stigma illustrates Robinson's (2013) concept of strategic identities. For Robinson (2013: 23) "strategic identity describes identities that serve a political, social or interpersonal function and are adopted by in-groups living under the surveillance of powerful out-groups." Thus identities like pansexual and queer can be interpreted as strategic as they allow women to avoid biphobia and hyper-sexualisation under the male gaze. As I discussed in Chapter 1, in post-feminist discourse performative bisexuality constitutes a playful sexual reflexivity that does not necessarily destabilise the compulsory heterosexual feminine self (see Boyer and Galupo 2015; Jackson 2009; McKenna 2002). Fahs (2009) argues that post-feminist raunch culture instils a form of "compulsory

bisexuality" where situational lesbian eroticism is incorporated into the sexual repertoire of otherwise heterosexual women for the pleasure of men to the extent that it is an almost expected sexual script (see Blackman 2009: 124; see also Blair and Hoskin 2014, 2015; Hayfield et al. 2013). However, rather than experiencing bisexuality as a form of post-feminist sexual empowerment, participants' accounts demonstrate how feminine bisexuality is sexualised and co-opted for the male gaze ("Send me pictures. Send me video").

For my participants, the hyper-sexualisation of their bisexuality makes it difficult to construct and express authentic bisexualities beyond the post-feminist "scandalous glamour object" paradigm (Blackman 2009: 124). In their study of performative bisexuality in the US, Boyer and Galupo (2015: 365) similarly observe that "women's sexualities are compromised through commodification and appropriation of the male gaze, which leaves little room for them to explore same-sex attraction on their own terms, as it serves allegiance to patriarchal constructions of pleasure" (see also Fahs 2009). For example, in complaining that "no one's ever just like 'oh, cool' and carries on the conversation," Miki observes how feminine bisexuality is positioned as deviant and a subject up for debate. The stigma and invalidation associated with this poses a significant barrier to articulating an "authentic" bisexual identity.

Given the hyper-sexualisation of feminine bisexuality, a commonly held perception is that bisexual women maintain hetero-patriarchal privilege by "failing" to come out as lesbian and "passing" as heterosexual (see Blair and Hoskin 2015, 2014; Hayfield et al. 2013; Ochs 1996; Wandrey et al. 2015). However, in light of their experiences of stigma, forced performativity, and erasure, all participants reject the notion of passing privilege. Frankie explains:

> It makes you feel really invisible and there's this… there's talk of it being like you know "passing privilege" you know, people will go like you LOOK heterosexual so that's a privilege and you know, you get away in all these situations but… (sighs) The idea of… being made invisible as being a positive thing is really frustrating.. and and it sucks! Because it's like its

> not... a good… affirming... Identity affirming experience to… to be told that you're not who you are, you know what I mean?

This was an emotional topic for participants. Previous research has found that these experiences of exclusion and erasure within the LGBTIQ community contribute to bisexuals' poorer overall health and wellbeing (Ebin 2012; Flanders et al. 2015, 2016; McLean 2008; McNair 2009; Pallotta-Chiarolli and Martin 2009). Many participants express desire to feel a sense of belonging within the LGBTIQ community but most have experienced microaggressions, politicised boundary maintenance, and gate-keeping from other community members who have certain ideas about who and what counts as "queer." Here, these microaggressions refer to subtle types of prejudice towards bisexual people often taking the form of "brief and commonplace daily verbal, behavioural, or environmental indignities, whether intentional or unintentional" that communicate hostile, derogatory or negative attitudes towards bisexuals (Sarno and Wright 2013: 64-65). For instance, participants frequently experience subtle uses of biphobic language, negative stereotypes or inferences that bisexual women are "inauthentic" or even privileged in the queer community. Such microaggressions are another example of the normativising protocols that prompted participants' disidentifications, as negative experiences within the queer community influenced participants' choices to adopt strategic identities – choosing certain labels rather than others depending on context (Robinson 2013).

Given the past and continuing exclusion of bisexuals from some queer and feminist communities (see Blair and Hoskin 2014; Esterberg 1995; Hayfield et al 2013; Stein 1997), bisexual women in relationships with heterosexual men were the least likely to engage with LGBTIQ communities for fear of being excluded (see also Comeau 2012; Hartman-Linck 2014). These participants experienced Muñoz's (1999) "normativising protocols," particularly from lesbians:

> I definitely feel like… (sighs) like I'm not properly.. gay.. like not a real lesbian.. I've got this gay friend who once referred to me as being "only

> half" gay. Which is really dumb because… (laughs) I dunno.. I mean, look at me! I'm so gay! Butch as fuck! (laughs) (Francesca, 20, pansexual)
>
> All my partner's friends are lesbians too and we'll all be out and they might say stuff like "the lesbians are here!" and I'm like (quietly) "well…I'm.. not.. but.." And it just makes me feel a bit… weird sometimes, I guess. Like, this one time early on I mentioned something about being bi and they all just sort of.. took a bit of a back step… (Jess, 25, bisexual)
>
> I was always a bit threatened by and afraid of lesbian women because I felt their rejection of me as not being gay enough… I've found them very, very afraid of the fact that I… am also attracted to men and it's... and it's… something that alienates me from that community… So, I do think… as a result I think it.. has meant that I strive to prove myself in relationships with women. Like I will... constantly… sort of… verbally validate my gayness… to them… Because I feel like they're always like questioning what I'm doing there or if I'm just using them… (Evie, 26, pansexual)

While there are social benefits to being misread as heterosexual or lesbian (e.g. avoiding biphobia), this is not affirming of bisexual identity. Participant experiences reflect broader stereotypes of bisexuals as untrustworthy, promiscuous or "fence-sitters" threatening the cohesion of gay and lesbian communities (see Daumer 1992; McLean 2008; Stein 1997; Zaylia 2009). Lesbians are portrayed as especially concerned with community gate-keeping, while bisexual women are "traitors" who are "sleeping with the enemy" (McLean 2008: 68; see also, Ault 1996; Israel and Mohr 2004; Stein 1997), in denial, or lacking courage to embrace their "true" lesbian identities (Weinberg et al. 1994). Participants' experiences of not being "gay enough" as bisexual or queer women, leads them to actively articulate their "gayness" as a defence mechanism in certain contexts.

Articulation is an important means of justifying authenticity and commitment to relationships. For Klein et al. (2007: 3) strategic identities are volitional, as they

must be manifested through "the purposeful expression of behaviours relevant to those norms conventionally associated with a salient social identity" (see also Robinson 2013). For example, Francesca attempts to justify her identity by emphasising that she is "butch as fuck," with female masculinity being associated with "authentic" gayness. In Esterberg's US study (1996: 276), bisexual women who are "traditionally feminine" often feel concerned that their sexuality is invisible to the wider public, especially other queer women. Conversely, for Stein (2010: 27) "the butch lesbian, having a marked lesbian body, enjoyed privileged status within the lesbian world as the authentic lesbian." In this case "gayness" or queerness is implicitly located in a politics of experience in keeping with the "ethnic" model of LGBTIQ identity (see Seidman 1997). Such experiential speaking by gay people is often essentialist in constructing standpoints that may be used to develop political struggles (Gamson 1995). This is problematic because the essentialist position, in which physical demonstrations ("I mean, look at me!") and verbal articulations of gayness ("I will constantly validate my gayness to them") become prerequisites for community membership and having a voice about identity politics. This marginalises those with diverse experiences of queerness. Participants' reflexive engagement with and critique of these essentialist identity politics further illuminate their processes of disidentification. Rather than merely accepting or rejecting dominant identity structures, they attempt to critically engage with lesbians' normativising projects (Muñoz 1999: 12).

Because of these tensions, participants disidentify with lesbian stereotypes. Like post-feminist rejections of "strident" second wave feminism, participants subtly distance themselves from their ideas of what lesbians are like. For example, as a young girl discovering her sexuality, Stella was "very afraid of becoming a lesbian." Max similarly worried that being a lesbian was "a bad thing," and Jess "for a lot of reasons, really just [does not] like that word." In keeping with the contemporary post-gay shift, Stein (2010: 226) observes that young women reject lesbianism, like feminism, as a thing of the past, "associating it with a separatist impulse they don't particularly admire." Similarly, in this post-feminist climate, the lesbian is caricatured as erotophobic and "man-hating," while

bisexuality is "a titillating diversion that does not challenge male dominance" (Monro 2015: 123). Others have questioned whether, in this context, claiming queerness is a less political choice (see Stein 2010). While I do not wish to suggest that participants only identify with terms like "pansexual" or "queer" because these are chic substitutes for the more politicised "lesbian" or the stigmatised "bisexual" (see Alarie and Gaudet 2013), I do posit that neoliberal, post-feminist, and post-gay discourses are instrumental in shaping young women's rejection of static, collective identities that limit their individualised definitions of sexual selfhood. How, then, can one make sense of these seemingly contradictory stances where identity labels are deployed but also shown to be problematic or unnecessary?

Discussion

In this chapter participants' narratives are used to illustrate a contemporary moment where young women's understandings of sexuality are much more fluid and provisional than in the past. I draw on Muñoz's (1999) disidentification theory to analyse the complex and often contradictory ways the women navigate neoliberal identity politics. I suggest that through their disidentificatory work, queer young women are opening up a politics of identity that has the potential to produce new ways of thinking about the contemporary sexual self beyond a homonormative post-feminism.

While participants recognise the importance of sexuality labels in the first section, in the second section I argue that neoliberal, post-feminist discourses influence an individualist rejection of labels. However, at the same time, as I observe throughout this chapter, sexuality labels do continue to have some meaning for women, as many demonstrate an extended, reflexive engagement with labels and identity politics. So what is their motivation for asserting that public identities do not matter? I suggest that in a homonormative, post-feminist context there is more to be gained from claiming ordinariness than emphasising minority status. Under neoliberalism, "identity politics" is increasingly used as a derogatory synonym for feminism and anti-heterosexism – akin to complaints of

"political correctness gone mad" (Bernstein 2005: 48). Both post-feminist and post-gay perspectives deploy these neoliberal notions of depoliticised selfhood. Neoliberal ideologies emphasise individuals as free, neutral citizens, with identity politics being reserved for "others," making the notion of the "ordinary" citizen gendered, raced, and classed. For example, as Hekman (2004: 6) argues, white, heterosexual men are never acknowledged as having an identity, instead, they are positioned as the neutral, "abstract citizen" of neoliberalism (see also Pateman 1989). Therefore, in neoliberal post-modernity, individual specificity is valued highly, prompting queer young women to simultaneously embrace niche identities that establish themselves as complex individuals, while avoiding the political stereotypes associated with more traditional collective identities.

Taking an intersectional approach reveals how the ability to claim neutral individuality, fluidity, or "ordinariness" is not only a product of neoliberalism, but is profoundly raced and classed. Participants' whiteness and middle-class status afford them a certain level of access to discourse and resources that allow them to embrace queer unintelligibility in a way that may not be accessible to more marginalised groups (for an example, see Yon-Leau and Muñoz-Laboy 2010). As Skeggs (2004: 53) points out "the method of constructing a biography is seen to be a neutral method, something one just does, rather than something dependent on access to discourse and resources." Indeed, participants who express ambivalence to labels are quintessential neoliberal, post-feminist subjects – young, white, middle-class, and university educated. Just as post-feminism repositions feminist politics as out-dated common sense (see Whelehan 2000), these participants portray dwelling on issues of labels and sexual identity as unnecessarily political, restrictive and minoritising in the post-gay context. Thus from their positions of privilege, it is easy for these white, middle-class young women to reject identity labels because they do not perceive a need to mobilise for rights based on collective gender or sexual identities (see also Savin-Williams 2005). This neoliberal, post-feminist focus on individualism challenges the possibility of collective mobilisation on the basis of shared oppressions as women and risks dismantling sexuality as an identity category. Therefore, rather than being evidence of queer post-structuralism in practice, I

argue that contemporary rejections of sexual identity labels are more a product of the neoliberal politics of normalisation (Richardson 2005).

However, at the same time as navigating identity politics, participants also engage in critical identity work within neoliberalism and post-feminism as they simultaneously incorporate and reject these influences on their understandings of gender and sexuality. I found that binary definitions of bisexuality constitute normativising protocols that invalidate participants' claims to queerness if their experiences do not adhere to expected definitions. Given that sexual identity is largely defined by sexual activity, bisexuality is seldom viewed as a legitimate sexual identity in its own right. In this system, bisexual women have their identities compromised when they enter into monogamous relationships with partners of a particular gender (see Comeau 2012; Hartman-Linck 2014; Tabatabai 2010).

With these experiences in mind, I suggest that rather than being entirely depoliticised and individualist, participants' rejections of certain identity labels can be interpreted as a disidentificatory "survival strategy" to allay stigma in contexts where queerness is less accepted and understood. Thus in this chapter I argue that queer young women are engaging with post-feminist and post-gay politics while also moving beyond to a new kind of queer sexual citizenship that takes a more critical view of gender and sexuality, or, as I have outlined elsewhere, a kind of "post-post-feminism" (Grant and Nash 2017; see also Gill 2016). In doing so, this research makes new connections between post-feminism and young, white, middle-class queer women's "post-identity politics identity politics" (Riggs 2010).

Throughout this chapter, I have argued that disidentification is a useful way to rethink the post-feminist/post-gay analysis. Instead of positioning the rejection of sexuality as an entirely neoliberal act, it can also be read as an example of subjects challenging and reinterpreting these cultural forms (Muñoz 1999: 12). Participants work on identity politics through their reflexive engagement and critical revisions of labels. They also work with contemporary neoliberal

identificatory structures through questioning the salience of sexual identities in favour of individuality. However, they also work against neoliberalism and homonormativity in their attempts to (re)articulate fluid sexual selves that do not always adhere to established sexual meta-narratives.

Analysing queer young women's complex experiences of identity construction using Muñoz's concept of disidentification also sheds necessary light on how identity may shape rural bisexual and queer young women's sexual health experiences. Compared with lesbian and heterosexual women, bisexual women report poorer mental health, lower likelihoods of self-disclosure and community connected-ness, and reduced sexual health literacy (McNair 2009; Mulligan and Heath 2007; Pallotta-Chiarolli and Martin 2009). In the following three chapters I argue that queer women's reflexive use of certain labels rather than others acts as a disidentificatory "survival strategy" in neoliberal rural health settings that do not accept their approaches to sexual identity. These experiences of simultaneously internalising, rejecting and re-negotiating neoliberal (post-feminist and post-gay) identity and health politics highlight a specific kind of queer sexual citizenship that I will explore in the coming chapters. In the next chapter, I will explore participants' experiences of sex education in school arguing that the biomedical, risk-based, and heteronormative messages contributed to their understandings of safe sex.

Chapter 4: Understanding Sex

Introduction

According to Winckle (2008: 12) "in sex education classes, what students learn about gender and sexuality is central to how they define themselves, and how they produce their gendered subjectivities." In Chapter 3, participants deployed neoliberal approaches to identity – emphasising that their queerness is unremarkable. However, these perspectives are called into question as participants engage with social institutions that do not accept queerness. In this chapter, I explore what participants learned in sex and relationships education (SRE) at school and how this shapes their understandings and experiences of sexuality and sexual health. Despite many women positioning themselves as neutral individuals in Chapter 3, the women's queerness troubles their attempts to be seen "just like everyone else," leading them to disidentify with heterosexist notions of "good sexual citizenship" and seek alternative sources of inclusive sexual health information and peer-support online. In this chapter, I argue that participants' experiences of SRE further demonstrate how they engage in disidentification as a survival mechanism in neoliberal, heterosexist health contexts.

In Australia, SRE is located in the Health and Physical Education Curriculum, but not all topics are compulsory, and the content is dependent on individual schools and the staff responsible for teaching in this area (Farrelly et al. 2007; Robinson et al. 2014). While Australian young people identify school-based SRE programs as their most useful source of sexual health information (Smith et al. 2011), LGBTIQ Australian young people consistently nominate school-based SRE as their least useful source of this information (see Hillier and Mitchell 2008; Hillier et al. 2010; Robinson et al. 2014). Several nation-wide initiatives have proposed to mitigate these shortcomings in SRE for LGBTIQ young people. Chief among these is the Safe Schools Coalition (SSC), Australia's first national, government-funded program aimed at reducing homophobia and transphobia in schools (for

an overview, see Law 2017).

In 2015, the SSC released a range of optional teaching resources for schools, which inspired controversy among conservatives, who claimed the program indoctrinates children with a "leftist agenda" and promotes "a radical view of gender and sexuality" (Donnelly 2016; McNally 2015). This prompted a government review of the program's appropriateness (see Louden 2016), amid calls for government funding for the SSC to be repealed (Anderson 2016). While the inquiry found that the learning materials provided by the SSC were in line with the National Curriculum, it recommended the program only be taught in secondary schools and some materials only be made available to students through counsellors (Louden 2016). Since the inquiry, SSC has been defunded in most states (Wiggins 2017; Wisby 2017).

Improving SRE in Tasmania is a government priority, given the state's high rates of youth pregnancy, STIs, domestic violence, and poor health literacy. SRE was first included in the Tasmanian Curriculum in 1987, when all Australian Government schools were mandated to provide health education. However, as is still the case nationally, the content and scope of SRE is left to the discretion of individual schools and teaching staff. In her 2008 study of SRE in Tasmanian schools, Winckle observes that Tasmanian approaches are often biological, heteronormative, and lack discussion of the ethical and emotional aspects of sex, gender, and sexual diversity. Winckle (2008) also argues that health and physical education teachers, who receive little or no training in the field, are responsible for delivering SRE.

Following Winckle's (2008) study, the State Government released the Tasmanian Sexual and Reproductive Health Strategic Framework (Department of Education 2012). This framework sought to reduce STIs and unplanned pregnancy, increase health literacy, and improve health equity among vulnerable populations. Subsequently, the current Tasmanian Curriculum Policy (see Department of Education 2012: 3) states that "all schools should offer all students a comprehensive, developmentally appropriate relationships and

sexuality education program" that includes information about sexual and physical development, reproduction, respectful relationships, and gender. The Relationships and Sexuality Education in Tasmanian Government Schools Strategy (2012-2014) stipulates that a commitment to embracing diversity and supporting LGBTIQ young people is integral to providing comprehensive and inclusive SRE to all students. Tasmanian schools have been particularly receptive to the SSC, with 22 Government schools joining the coalition since 2015. The Tasmanian SSC also provides professional learning support for teachers and staff, reporting particularly high demand in 2015-2016, given the national controversy around the SSC (Working It Out 2016). However, in line with the Federal defunding of the SSC, in 2017 the Tasmanian State Government has not committed funding to renew the program (Wisby 2017).

The debates around the SSC in 2015 provide the context for participant contributions to this study. While Government approaches in this area have become more inclusive, my participants attended secondary school in Tasmania between 2002 and 2014 and therefore missed the opportunity to benefit from more recent, comprehensive SRE programs. Subsequently, the women I spoke to are passionate about improving SRE for Tasmanian LGBTIQ young people, and are adamant that more inclusive programs like those provided by the SSC would have been useful for them when they were at school. As I will discuss in this chapter, school-based SRE did not adequately inform or prepare participants for safer sexual practices and, instead, negatively impacted their understandings of sex and sexuality. This chapter is structured around the four discourses identified in the women's accounts of SRE in Tasmania: 1) Sex as Biology; 2) Sex as Risk; 3) Compulsory Heterosexuality; 4) Crowdsourcing Queer Sex Education.

Sex as Biology

As illustrated by the SSC controversy, sex education is historically a contested site in Australian school curricula, due to the highly emotive notions of morality that become entangled in any discussion around sex, sexuality, and relationships (Hillier and Mitchell 2008). Despite ample evidence to the contrary (see Franklin

et al. 1997; Kim et al. 1997), there has been international concern that SRE encourages sexual experimentation among young people, prompting a significant focus on "abstinence only" approaches, particularly in the US. While abstinence rhetoric is less prevalent in Australia, Farrelly et al. (2007) argue that similar conservative discourses have shaped Australian SRE curricula through their focus on reproduction. For example, with the introduction of the Relationships and Sexuality Education in Tasmanian Government Schools Strategy in 2012, the Australian Christian Lobby opposed the inclusion of sexuality and gender issues, emphasising the need to focus on "traditional family" and reproduction (ABC Online 2012; Prismall 2012).

To avoid such controversy, much Australian SRE is delivered as "scientific understandings of body functioning," positioning sexuality as being for the purpose of reproduction (Farrelly et al. 2007: 65). However, this has the effect of naturalising, or normalising, heterosexuality while claiming to present neutral scientific fact. In this section, I will show how biomedical messages shape participants' understandings of sex and sexuality. Following Winckle (2008), I argue that Tasmanian SRE excludes queer experiences through the naturalisation of heterosexuality. This further marginalises Tasmanian queer young people and deters them from accessing health services.

Sex education was a popular topic in the interviews. All participants passionately shared their experiences and views on how school-based SRE could be improved. Thirteen participants reported receiving some school-based SRE in Tasmania, but this varied: Harley, attended a Catholic school and had "one lesson." Stella attended a government school and received "a plethora of awkward sex education." Jayden also attended a government school but mentioned that she was absent during the week the SRE program was offered and subsequently missed out. This illustrates the need for on-going, whole-school approaches to SRE (see Blackmore et al. 1996; Harrison 2000; Senior et al. 2014), which are only now being incorporated into the Tasmanian Curriculum. Participants report learning about the following topics in SRE: reproduction, menstruation and other bodily changes during puberty,

contraceptive methods, and STI prevention. Two participants reported receiving SRE that included discussion of gender, sexuality, and healthy relationships. No participants received SRE that covered LGBTIQ identity, relationships, experiences, or sexual health. No participants learned about lesbian, bisexual or queer women's health and relationships at school.

Participants' accounts of SRE are overwhelmingly negative. A common complaint is that it was "too little, too late, too biological" (see also Blake 2008; Formby 2011b; Senior et al. 2014; Winckle 2008). To neutralise or avoid the controversial or awkward nature of SRE, the focus of much of the participants' SRE was on biological aspects of puberty, genitalia, and reproduction:

> The information was really… um… kind of anatomical or... facts about like... yeah, anatomical, like a biology lesson. You know, it was about what ovaries are... instead of... actual… sex education… (Carrie, 23, bisexual).

> High school… I guess… Was decent but it like… it was a lot of the anatomical diagrams of genitals and just labeling them… Which is fairly irrelevant… (laughs) Yeah… (Isabelle, 21, queer).

> They didn't even cover like the useful stuff… like they didn't talk about… you know, how to keep your junk clean! (laughs) Like I remember the first time I got a urinary tract infection and I was like "WHAT is HHHHAPPENING to my body!?" You know… and I like talked to mum about what it is and I was like 16 and I'd been through years and years of sexual education and this is like a sexual health related thing and no one was ever like "Hey. Listen…. This is what's going to happen." That sort of thing would be more useful than colouring in a diagram! You know? Things that kids actually need to know that usually they don't, because nobody tells them! (Sloane, 26, queer).

Senior et al. (2014) suggest that SRE programs must be engaging and meaningful for students, in order to achieve improved youth sexual and reproductive health

literacy. However, as my participants observe, the delivery of SRE is not applicable to their lived experiences. In the extract above, Carrie distinguishes between biomedical approaches and more holistic or practical approaches that focus on the social aspects of sex and relationships, which she saw as "actual" sex education (see Senior et al. 2014: 165). Similarly, by referring to looking at diagrams as "irrelevant," Isabelle emphasises the need for more applied information and learning activities. As Winckle (2008) observes, unlike other subjects, Tasmanian schools rarely use constructively aligned intended learning outcomes, assessment, or student feedback procedures in their delivery of SRE. Instead, by focusing on anatomical aspects, SRE is sanitised and conveniently avoids critical discussions of the complex social and relational aspects of sex, gender, and relationships.

Both neoliberal and post-feminist discourses "(re)privatise" sex, sexuality and gender in favour of emphasising the "neutral," rational, and free individual (Duggan 2012). Just as neoliberal economic projects advocate for the privatisation of state resources and social services, the biomedical focus of SRE implicitly positions sex and sexuality as something that should only be discussed in private, rather than being the responsibility of school systems. Sloane's example of having to ask her mum what to do about a urinary tract infection, despite having "years and years of sexual education" illustrates the privatisation of applied discussions of sex and health. Furthermore, the scientific nature of participants' SRE appeals to the value neoliberalism places on rationalism and scientific fact to support "neutrality." Biomedical approaches to SRE and health intersect with neoliberalism as individuals are positioned as rational health consumers who, given accurate information, will make the "right," "healthy choices" and will take individual responsibility to access healthcare when required (see Adam 2005; Ayo 2012; Elliott 2014). However, these models are problematic as they fail to take into account the structural issues that produce health disparities, for example, unequal access to health information and services due to geographical location, race, class, and sexuality. As I will discuss in the forthcoming sections, the biomedical focus of participants' SRE results in a risk-based approach that assumes heterosexuality.

Sex as Risk

Sex education programs were originally conceived as a remedy for physical problems, such as STIs, and for managing the social problems of perceived moral decay (Bay-Cheng 2003: 64). Subsequently, deficit model, or risk-based approaches have been common in both religious and secular SRE approaches (Farrelly et al. 2007: 65). In her germinal ethnographic study of SRE in the US, Fine (1988) identifies three common themes in SRE discourse: 1) "sexuality as violence," in which sex is positioned as inherently damaging; 2) "sexuality as victimisation," where sex holds multiple possibilities for physical and psychological victimisation; and 3) "sexuality as morality," which emphasises the Judeo-Christian ideals of self-control, will power, and purity. Fuelled by moral panics around youth pregnancy, sexualisation, and rising rates of STIs, problem-oriented, risk-minimisation models have similarly shaped contemporary Australian SRE approaches (Bay-Cheng 2003; Senior et al. 2014).

As a rural and geographically isolated state with a range of socio-economic and health disparities, Tasmanian sexual health promotion and SRE deploy specific health risk discourses. As Bishop (2013) argues, Tasmanian media and public policy position Tasmanian youth as "high risk," given the conditions of "chronic rural disadvantage" in many parts of the state. Tasmanian youth experience poor educational outcomes and retention rates, high unemployment, reduced health outcomes, and some of the highest rates of youth suicide in the nation (Bhole 2017). High youth pregnancy and rising rates of STIs are interpreted as products of poor education and unsuccessful targeting of public health promotion to Tasmanian young people (see Bishop 2013). Therefore, risk-based approaches to SRE in Tasmania are understandably seen as a means of combatting the systemic issues faced by young people in the state. However, in this section I will argue that these risk-based approaches to SRE in Tasmania negatively shape participants' understandings of sex, reinforce a hetero-patriarchal gender order, and do not promote sexual health literacy.

School-based SRE is a mechanism of social reproduction and control. Young people learn how to perform good sexual citizenship through conscious and subconscious lessons (see Elliott 2014; Leahy 2014; Powell 2007). Implicit in this is a reproduction of the hetero-patriarchal gender order and gendered notions of sexual risk (Burkett and Hamilton 2012; Elliott 2014; Winckle 2008). Strategies for promoting youth sexual health often reinforce gendered sexual scripts that position young men's sexuality as uncontrollable while placing young women in the role of sexual gate-keepers (Powell 2007: 23). Sexual health promotional slogans such as "tell him if it's not on it's not on" imply that women are responsible for the practice of safer sex (Burkett and Hamilton 2012). Such discourses often result in the moralising and policing of young women's sexuality (see Amaro 1995; Burkett and Hamilton 2012; Jackson and Weatherall 2012; Powell 2007). In these discourses, youth sex is positioned as a site of anxiety and risk for young women (see Bishop 2013).

These discourses are evident in participant accounts of sex education. Participants describe the overarching tone of their SRE as accusatory and largely focused on unplanned youth pregnancy and the contraction of STIs. Participants describe the frequent use of shock tactics and imagery in their "fear-based" SRE:

> I just got all these graphic close up pictures of gonorrhoea and chlamydia and stuff, but it was all just like... it wasn't like, oh you can get these and you could have no symptoms for a while… it was like AS SOON AS YOU GET IT, You will TURN GREEN and have PUS EVERYWHERE! And I was like Oh My God! Yeah... That was… That was… What I thought would happen as soon as you got an STI. You would immediately know and it would be horrific and you basically wouldn't be able to use your vagina ever again! (Sloane, 26, Queer)

> When I was at [Catholic high school] they showed us a video of a pap smear, like, close-up! I have seen a pap smear take place! I was like 'I'm going to be a nun! I'm going into the church!' (laughs) (Pip, 20, pansexual)

> It was just about all the STIs, what to wear, how not to get them… Like contraction methods…They had all these pictures… They said how effective it was and blah blah, but they didn't really like… say… how you do it or how to make it safe… they just said… you know (laughing) You can get pregnant from this you can get pregnant from… Oh! And it all just made me so scared! (laughing) I was like 'I'm never having sex!' I was never doing that! (Middy, 19, fluid)

The extracts above reflect the "biological determinist" and "risk minimisation" discourses that Farrelly et al. (2007) observe in the Australian Curriculum. Farrelly et al. (2007: 65) argue that dominant discourses in conservative sex education assume that adolescence is a biologically determined period of hypersexuality, requiring adult control through deterrence or risk management (see also Bay-Cheng 2003). As Sloane suggests, her SRE was not only medically inaccurate and alarmist ("turn green," "pus everywhere"), but danger and risk were used as deterrents to prevent youth sex ("you basically wouldn't be able to use your vagina ever again!"), rather than productively engaging with young people about sex, sexuality, and relationships (see Powell 2007: 22).

The use of close-up medical imagery of female genitalia negatively affected Pip, who was "grossed out" by the video and half-jokingly vowed to remain abstinent ("I'm going to be a nun!") rather than undergo the routine procedure. This is problematic as risk minimisation discourses in SRE largely presuppose a rational non-gendered learner, who, when equipped with accurate medical information about safer sexual practices, will be capable of making effective sexual and reproductive decisions (Farrelly et al. 2007: 66). However, risk-based approaches to teaching SRE, including the deliberate use of shocking medical imagery, did not result in rational responses among participants. Rather than "enabling them to make socially desirable decisions regarding sexual and reproductive relationships" (Farrelly et al. 2007: 66), these participants' SRE deterred them from seeking routine sexual healthcare and instead associated sex with fear. The heavy focus on medical risk and fear or morality-based messages in school-based SRE is increasingly highlighted as a flaw in international

approaches to SRE (see Allen 2004, 2005; Bay-Cheng 2003; Carmody and Ovenden 2013; Fine 1988). Instead of preparing "students to develop respectful relationships, make safe choices, and address sex related issues," as the Relationships and Sexuality Education in Tasmanian Government Schools Strategy (Department of Education 2012) claims, participant experiences demonstrate that SRE reproduces gender and sexual inequalities through its problem-based focus on personal responsibility and self-regulation.

As young women, this discourse is received as particularly punitive. For example, Max recounts an experience of being "taught how to not get raped" in SRE. The teacher explained that "being out late at night is dangerous for women. And that wearing particular clothes is dangerous for women. Don't hang around certain people…" Max notes that the boys in her class were not given the same lesson about rape, constructing sexual risk management as a feminine responsibility and ignoring the agency of men and boys (Gavey 1991). Similarly, Sloane is regretful that sex was framed negatively for young women in her SRE, with no discussion of "the good things about sex." Francesca shares a similar account of how her SRE impacts the way she feels about sex:

> It affected me, because it caused… I thought like it, it… it created standards… and it made me feel like sex had nothing to do with me it was all about the dude and only a dude and it… made me feel like an object… that it wasn't for me… and it caused something to happen which was not good… and it just perpetuated all these stereotypes and made me feel like an object. And.. like.. I knew nothing about sex, I knew nothing about what to do… so it like, it's caused some serious problems for me… (Francesca, 20, pansexual)

Francesca articulates the implications of Fine's (1988) missing discourse of feminine desire in SRE. Disproportionate emphasis is placed on the damaging and victimising aspects of sex for young women, without acknowledging the positives. Winckle (2008) argues that young women and girls are frequently isolated in the Tasmanian SRE classroom. Their experiences, questions, and

concerns are often derailed or ridiculed by their male classmates. For Dempsey et al. (2001: 68) by "focusing on sexuality which is heterosexual, penetrative, and reproductive, male sexuality is constructed as active and expressive, in need of being kept in check by the more passive, responsible female." This discourse is common in public health campaigns encouraging young women to "just say no" to unwanted sex (see Burkett and Hamilton 2012). However, as Buzwell and Rosenthal (1996) argue, sexual self-efficacy must be understood in broader terms that also incorporate women's ability to assert their own sexual desires in addition to taking reasonable precautions during sex (see also Allen 2003; Amaro 1995). Raymond (1994) argues that the disproportionate focus on victimisation and risk in SRE presents young women with few alternative modes of how to be a sexual actor (see also Tolman 1994). In Francesca's account, receiving SRE that positions women as victims, or, passive objects of male desire, contributes to her negative sexual experiences ("it caused something to happen which was not good;" "it caused some serious problems for me") because of the low sexual self-efficacy it fosters ("it made me feel like sex had nothing to do with me;" "I knew nothing about what to do").

Compulsory Heterosexuality

In addition to deterring or reducing youth sexual behaviour, school-based SRE also contributes to producing a specific kind of sexuality (Bay-Cheng 2003: 66; Haywood 1996). In the US, abstinence-only sex education receives considerable federal funding. In the UK, until 2003, Section 28 of the Local Government Act prohibited the "promoting" of homosexuality (see Moran 2001). In contrast, Australia has takes a more moderate stance on school-based SRE, especially in the promotion of pregnancy and disease prevention and "healthy relationships" (Farrelly et al. 2007; Hillier and Mitchell 2008). However, numerous Australian and international studies reveal that school-based SRE programs are seldom explicitly inclusive of LGBTIQ students' needs and experiences. Rather, the goal of these programs is to prepare "every adolescent to form one-half of a heterosexual married couple" (Hillier and Mitchell 2008: 212; see also Elliott 2014; Formby 2011b; Hillier et al. 2010; Jones et al. 2016; Robinson et al. 2014).

In this section I show how the compulsory heterosexuality of Tasmanian SRE causes participants to disidentify with dominant notions of sexual citizenship and seek alternative sources of sexual health information. I argue that these experiences complicate participants' homonormativity and post-feminist sensibilities (discussed in Chapter 3), further illustrating their processes of disidentification as a survival strategy in heteronormative contexts.

The most common complaint about SRE from participants is that it only covered heterosexual reproductive sex and relationships. No participants' SRE covered queer women's sexuality and sexual health:

> None of them ever talked about queer stuff, especially at a Catholic school, because that's essentially banned…Yeah. It just… basically… At school… it wasn't ever discussed… (Francesca, 20, pansexual)

> They just, straight away they just assume you're straight… They never talked about, like, gay stuff… (Pip, 20, pansexual)

> There was nothing about queerness or same sex um… sex ed. At all. That literally wasn't even mentioned. We certainly weren't encouraged to explore our sexuality or gender, or anything like that. (Jess, 25, bisexual)

> I don't think they would even acknowledge that any sort of queer person existed. (Audrey, 20, bisexual)

These accounts demonstrate how compulsory heterosexuality is reproduced through the singular focus on penetrative heterosex in SRE. Rubin (1989) importantly exposes the hierarchical system of sexualities in western culture whereby institutionalised support is given to those sexualities and acts that are valued and normalised (e.g. monogamous/marital, reproductive heterosexual sex), while those which are not (e.g. homosexuality, kink, casual or group sex, sex work) are medicalised or stigmatised as perverse. Similarly, Rich (1986: 35)

identifies heterosexuality as a "political institution" that maintains male power by positioning female heterosexuality as natural and erasing lesbian existence. In the extracts above compulsory heterosexuality is institutionalised in school-based SRE through its positioning as neutral or normal. In contrast, queerness is represented as deviant and "inappropriate" to discuss in schools (Formby 2011b). Multiple participants express the theme of invalidation and erasure of queer experience, describing it as something that was "never talked about." By omitting the possibility of queer women's sexualities and relationships, heteronormative SRE reproduces the unintelligibility of sex between women:

> I didn't have any idea about how lesbians have sex… Like how do women have sex? Maybe…. Maybe they just take off their clothes and kiss? (laughs) Like… And things like oral sex were never… Or they were always explained from the guy's point of view, like blow-jobs… It was never like you can go down on a woman… It was never… A thing... because… I remember them saying, 'make sure you put a condom on if you're giving a guy a blow-job...' But, like, there was nothing on like dental dams… Or like... going down on a woman or things like that. A lot of things were like a huge mystery to me. (Sloane, 26, queer)

> When you're in high school and the only thing that counts as sex is putting a dick in a vagina and that's it... like oral and anything, that's just... that's just warm up for the 'real' thing... the 'real deal.' If you've only done that, that's not sex. There's a huge erasure for people who don't have sex like that, or are uncomfortable or don't… get off to penetrative sex, or don't want to do it because of trauma or anything, so for me, it was... I'd been having sex for a long time, but people were like 'no that's not… you're not… you're just waiting for the real deal', or 'you're going to be a virgin your whole life cause you don't want'… that… (Pip, 20, pansexual)

For Butler (1991: 17) lesbian and queer women's sexualities are constructed as perverse copies of heterosexuality, which wrongly privileges heterosexuality as the "prior truth," or the norm (see also Rich 1986). As in Pip's experience, the

heteronormative focus of SRE invalidates queer women's sexuality by privileging penetrative sex as "the real deal," or the most culturally valued form of sex. This also reflects participant experiences of bi-erasure (discussed in Chapter 3), because framing heterosexual sex as "the only thing that counts" fails to acknowledge the significance of their same-gender experiences. As I argued in the previous chapter, feminine bisexuality is routinely positioned as a superficial phase or an "inauthentic" performance to attract male attention, with heterosexuality being seen as the default orientation for women (Boyer and Galupo 2015; Fahs 2009; Hayfield et al. 2013). As I will discuss further in Chapter 5, sexual health promotion fails to adequately inform bisexual women about safer sexual practices with female partners. For example, Sloane could not conceive lesbian sex due to the androcentric heteronormativity of her SRE ("they were always explained from the guy's point of view").

Participants' experiences of heteronormative SRE illustrate how neoliberalism exerts social control at a largely imperceptible, discursive level (Kerr and Mkandawire 2012). Sloane's inability to comprehend the practicalities of lesbian sex, including safer sexual practices ("there was nothing on like dental dams"), is a product of the process through which neoliberal agendas regulate sexual identities. Kerr and Mkandawire (2012: 461) argue that neoliberal public health and education policy produces compulsory heterosexuality by implicitly constructing heterosexual men as the normative social identity (see also Hekman 2004). For Elliott (2014: 212), neoliberal approaches superficially valorise diversity while depoliticising difference (see also Hale 2005). To perform "good neoliberal citizenship" queer subjects must be self-managing and responsible while conforming to, rather than challenging, existing institutions (Elliott 2014: 212; see also Duggan 2002). Although Duggan (2002) discusses how homosexuality has been incorporated into neoliberal citizenship in the US through homonormativity, her discussion is largely focused on the assimilation of white, urban, gay men as depoliticised consumer citizens, with little direct consideration of queer women's experiences (see also Brown 2012: 1067). Therefore, explaining SRE "from the guy's point of view" is a result of the political rationalities that intentionally blur racial, gender, and economic

inequalities in favour of the abstract (male) neoliberal sexual subject (Kerr and Mkandawire 2012).

Sloane identifies queer women's absence in her SRE by noting the lack of information about dental dams. While dental dams are a technology that is commonly called on as evidence that queer women's sexual practices are (or, in the case of my participants, are not) being made visible through SRE, their use in everyday practice is rare (e.g. Power et al. 2009). As I will explore in greater detail in Chapter 5, dental dams carry a symbolic significance in public health discourse as "the lesbian answer to the condom" in narratives of sexual safety and risk (Cox and McNair 2009). Therefore, exploring alternative ways to engage and incorporate queer women's experiences into SRE is necessary. Successful lesbian, bisexual and queer women's health campaigns focus on non-latex risk reduction strategies such as communication and consent, building sexual self-efficacy, hygiene and toy care (see Albury 2015). Illes (2012) argues that reframing SRE to focus on sexual citizenship and positioning sex and sexuality as civic engagement would promote youth sexual agency and critical thinking more effectively than current heteronormative, risk-based strategies. As I will discuss in the following section, holistic approaches to SRE that are grounded in personal experience and informed by research are not only possible and necessary, but also preferred by rural queer women.

SRE conveys implicit messages about gender and sexuality (see also Elliott 2014). Critical education scholars observe that in addition to conveying factual knowledge, the institution of education also reproduces structural inequalities by implicitly transmitting the cultural dispositions of dominant groups through the "hidden curriculum" (Bourdieu and Passeron 1977; Fields 2008). LGBTIQ students in previous Australian studies (Hillier et al. 2010; Robinson et al. 2014) report receiving no LGBTIQ-inclusive school-based SRE, but are subject to discrimination and hypersexualisation from peers and teachers on the basis of their sexuality. This may be interpreted as a hidden curriculum that reinforces compulsory heterosexuality and reproduces the construction of non-heterosexual identities as sexually deviant (see Rubin 1989). Participants' SRE

reinforces compulsory heterosexuality by positioning boys and girls as separate subjects, biologically and socially. Elliott (2014: 218) observes how neoliberal SRE often represents heterosexuality as "unequal and antagonistic," reflecting a "men are from Mars, women are from Venus" approach common in post-feminist gender representations (see Gill 2007). Participants challenge this aspect of their SRE, arguing for a more integrated environment:

> The first thing I didn't like was how… divided sex ed was. Boys in one room. Girls in the other. Which is ridiculous, because really, if we want to know how all of it works, we should be taught together. With everybody. (Max, 21, bisexual)

> They need to stop separating them into boys and girls… like, dudes need to know about chick stuff and chicks need to know about dude stuff too! (Jayden, 20, pansexual)

> Being separated into girls' and boys' classes, they just assume girls need to learn about stuff with boys and boys need to learn about stuff with girls. (Francesca, 20, pansexual)

> They tell the girls what to do with the boys and they tell the boys what to do with the girls but they don't… Mix them together... They don't tell the girls what to do with girls or the boys what to with boys… It's like how do you find out? (Miki, 25, bisexual)

In these participants' framings, separating SRE into "girls' and boys' classes" reproduces Bulter's (1990) matrix of intelligibility. For Butler (1990: 23) "intelligible genders are those which in some sense institute and maintain relations of coherence and continuity among sex, gender, sexual practice, and desire." The participants' gender segregated SRE classes perpetuate this matrix of intelligibility as it is assumed that as young women and girls (sex) they are implicitly feminine (gender) and heterosexual (sexual practice and desire). Furthermore, Butler (1990: 24) argues that "the cultural matrix through which

gender identity has become intelligible requires that certain kinds of identities cannot exist." However, from an intersectional perspective one might mount strong arguments for sustaining gendered divisions in SRE classrooms, particularly in light of cultural and religious sensitivities. Winckle (2008) observes that in mixed gender SRE classes girls participate less in group discussions and are more susceptible to gendered harassment from boys. Furthermore, given feminist calls for more autonomous "safe spaces" in schools for women and other marginalised groups, participants' preference for mixed gender SRE classes is intriguing. Arguably, the main aspect of gender segregated SRE that participants take issue with is that it does not sensitively allow for gender diversity and implies that gender, sex and sexuality are innately linked for everyone. Therefore, participants' accounts demonstrate the need for more inclusive language and framing around gender and sexuality in SRE and more inclusion of information relevant to people of all sexes/genders regardless of those present in the class.

The implication of heterosexist SRE for participants is that it made them believe that what they learned in SRE was not applicable to their experiences. As I will discuss in Chapters 5 and 6, this shapes participants' approaches to sexual health as young adults. Formby (2011b: 255) argues that the "dominant (heterosexual) sexual culture permeating health and education contexts influences the sexual cultures of LGB young people, and affects their sexual behaviours and take up of health services." This is the case for participants in my study, whose heteronormative SRE perpetuated ambivalence about safe sex between women and misconceptions that queer women are immune to STIs (see McNair 2009; Logie 2014; Richardson 2000):

> There's all these misconceptions, especially growing up as a queer kid… cause you don't really get taught about… sexual health for queer people… it's all just for straight people… and I remember being told in high school that you don't need a pap smear unless you've had a… sex with a man… so I was like, oh, yeah I'm probably never going to have to. And that's really bad, cause, in terms of sexual health for same sex [attracted]… people…

> there is a whole lot of stuff that you actually really need to know! And I never knew until I was an adult and had done all my experimenting! (Jess, 25, bisexual)

> I still have no idea whether I'm supposed to get a pap smear or not… It was really unclear and I've since been told all sorts of stuff… like, different stuff from different people. So I've got no idea. It's that sort of thing – we just aren't taught this stuff, so often we only find stuff out when it's too late. (Harley, 19, asexual)

As noted in Chapter 1, large studies of Australian secondary school students reveal same gender attracted young people are sexually active earlier on average than heterosexual young people (see Hillier and Mitchell 2008; Smith et al. 2011). Queer young women often discover their same gender attractions at a later age, but report higher rates of heterosexual behaviour than same gender attracted young men (Dempsey et al. 2001: 67-68; Hillier et al. 2010). Given these experiences, it is concerning that queer young women are likely to disengage from heteronormative school-based SRE, seeing it as irrelevant to their experiences ("It's all just for straight people"), and instead learn by "experimentation" (see Hillier and Mitchell 2008).

The detrimental impact of inadequate sexuality and gender-affirming SRE and health information for LGBTIQ communities is well documented (see Formby 2011b; Hillier and Mitchel 2008; Jones and Hillier 2013; Shannon 2016), however, I argue that this is especially isolating for bisexual and queer young women in Tasmania. Tasmanian gay men are less likely than those in Victoria and New South Wales to have been tested for HIV and are more likely to access sexual health information and social support online (Lea et al. 2015). Lea et al. (2015) also suggest that a lack of queer visibility limits LGBTIQ Tasmanians' access to inclusive sexuality and sexual health information. I posit that similar circumstances shape Tasmanian queer women's understandings and experiences of sexuality and sexual health. In the extract above, Jess raises the important point that it is only as an adult engaged in "the gay scene" that she has

learned about queer sexual health. This sentiment is common among participants, however, given the limited scene in Tasmania, especially in areas outside of Hobart, participants stress the need for more comprehensive school-based SRE and public health promotion specific to bisexual and queer women's experiences in Tasmania.

Crowdsourcing (Queer) Sex Education

Following arguments made in Chapter 3, participants' borrowing from queer and feminist politics while occupying a post-feminist/post-gay space may be explained using Muñoz's (1999) concept of disidentification. Throughout this thesis, I argue that disidentification is a survival strategy in the heteronormative Tasmanian context that invalidates or erases bisexual and queer women's identities. Deploying homonormativity enables queer young women to access and engage with institutions and services in rural spaces without additional barriers. For Muñoz (1999: 11), disidentifying is a comment on the oppressive nature of hegemonic systems that fail to accommodate diversity. This is especially evident in the ways in which participants discuss their use of the Internet and social media to self-educate in the wake of their inadequate SRE from school.

Young people overwhelmingly rely on the Internet for health information (see Fergie et al. 2013; Fox and Jones 2009; Gray et al. 2005; Lenhart et al. 2005). Several Australian and international studies identify the Internet's appeal as a sex education resource for young people, given the stigma around discussing sex and sexual health in the West (see Evers et al. 2013; Jones and Biddlecom 2011; Simon and Daneback 2013). Australian young people nominate the Internet as their preferred means of accessing sexual health information, despite expressing lower levels of trust in these sources (Keys et al. 2008). Although young people's widespread use of social media encourages some health services and organisations to use social networking sites for youth-oriented public health promotion, Evers et al. (2013) argue that Australian young people are less likely to engage with sexual health promotion through popular sites like Facebook, due

to the lack of anonymity and risk of embarrassment. Instead, Google searches are the most common means of accessing health information (Byron 2015).

Given the dearth of school-based SRE that is explicitly inclusive of LGBTIQ experiences, LGBTIQ Australian young people consistently identify the Internet as their most important source of information on sex, gender, same-gender relationships, and sexual health (Hiller et al. 2010; Hillier and Mitchell 2008; Robinson et al. 2014). Robinson et al. (2014: 29) find this to be particularly the case for lesbian, bisexual, and queer young women, who report receiving no comprehensive or accurate information about lesbian safe sex and relationships from either teachers or health professionals.

I asked participants how they had "filled in the gaps" in their knowledge about sex and sexual health for queer women. The Internet is the most important source of information among participants. In the interviews participants frequently mentioned articles they had read about sexuality online, referred me to websites they had found useful, discussed online supports and social groups and mentioned their engagement in online feminist and LGBTIQ activism. However, when I initially asked where they had gained information other than through school-based SRE, participants were often hesitant or embarrassed to admit the significance of the Internet, despite placing great value on the information and resources they sought online (see also Keys et al. 2008), Amid concerns around increased Internet and social media usage among young people are assumptions that online information cannot be trusted and young people are ill-equipped to assess the validity of sources. This likely influenced participants' hesitancy to admit their reliance on it. Participants all exhibit verbal and physical cues that reflect the lower status of online sources, as opposed to information generated and distributed by institutions and "experts" (see Simon and Daneback 2013: 310). However, as university-educated, privileged young women, participants are adept at critically evaluating online sources:

> I feel like you can take some things at face value online but, um, you know, someone can preach something as the truth and you could take it as black

> and white, but it doesn't take into account the multifaceted perspectives and stuff… I think straight sex education is quite useful on the Internet because it can be really comprehensive… But you could accidentally read some urban legend and take it at face value or misunderstand something completely… I think it can be a storm in a teacup if its handled wrong. (Audrey, 20, bisexual)

> Half the time, I'm like… 'Is what I researched correct? Do I have to go back and go find it out again to work out source checking,' because I didn't know about that stuff when I was… younger… But I think it is probably the most useful source of information currently, if you know how to take it. (Carrie, 23, bisexual)

Here, participants position themselves as "post-girl power" critical girls, active and capable of "source checking" when engaging with information online (see Harris and Dobson 2015). Participants' emphasis on self-education arguably reflects the neoliberal and post-feminist (re)privatising and "responsibilising" discourses discussed throughout this thesis. By establishing themselves as active consumers and producers of sexual knowledge online, participants attempt to overcome the stereotypical representations of Tasmanian rural youth as "risky" sexual subjects and create a sense of agency (see also Bishop 2013). Despite receiving insufficient SRE in school, participants demonstrate the lengths they have gone to in order to become responsible and informed sexual citizens. Frankie mentions "putting a lot of energy into self-education" and Jayden stresses that she has "done loads of research." Some women present this as an unproblematic, individualist process. For example, Carrie explains that she "would look something up online and then just know." By representing themselves as active and responsible self-educators, participants adhere to neoliberal imperatives for queer sexual subjects to perform "good" sexual citizenship through desiring and practicing individualist self-advancement (Duggan 2012; Elliott 2014).

However, at the same time, there are opportunities for subverting these

individualist, neoliberal approaches to sex and health through focusing on the need for a critical sensibility. Despite embracing the post-feminist "can do girl" discourse in their efforts to self-educate using the Internet (see Harris 2004), participants' emphasis on drawing information and support from online communities and peer-generated resources problematises their positioning as homonormative, post-feminist women. When discussing sex education, 11 participants told me that they saw their participation in this research as a way of helping others and advocating for change by sharing their experiences. Similarly, participants often mentioned their engagement in Facebook groups, through which they were able to engage in consciousness-raising and skill-sharing by providing sexual and mental health advice to younger queer women. For participants, online LGBTIQ communities are important for information and skill sharing:

> I've just had to do loads of research… [I've listened to] loads of YouTubers… I've found forums, Facebook groups… Web comics… I think the best way to learn about sex is to hear it from another human. Instead of that medical… way that… is… in sex ed. It's a lot better to hear the personal experiences of everything that can go wrong and right... and that's a lot better because you're not just getting 'here's the science' you're also getting… here's... what actually happens… (Jayden, 20, pansexual)

While Evers et al. (2013) and Byron's (2015) heterosexual participants were unlikely to engage with sexuality and sexual health information through social media, participants in this study avidly use sites like Tumblr, Facebook, and YouTube to access and share such resources. Explaining how she made up for her lack of SRE at school, Jayden emphasises the role peer support and experiential knowledge played in gaining information about sexuality and sexual health. Here, Jayden's ideal SRE coincides with Farrelly et al.'s (2007: 66) "holistic model" of sex-positive, emancipatory SRE that positions sex and sexuality as a healthy part of individuality and self-realisation. Rather than focusing on abstract biological facts or risks ("instead of that medical way that is

in sex ed"), the information Jayden accesses online is based on lived experience ("here's… what actually happens") (see also Bay-Cheng 2003). Arguably, due to heteronormativity and discrimination in major institutions (e.g. education, health), participants place greater value on sexual health information generated either by peers (e.g. YouTubers, Facebook groups, web comics, zines) or trusted community organisations (e.g. Working It Out, ACON, LGBTI Health Alliance, LGBTI Network, Minus18, YGender) (see also Robinson et al. 2014).

In this section I have discussed how, in the absence of relevant and inclusive school-based SRE for Tasmanian queer women, participants use the Internet to learn about queer identities, health, and relationships. Here, the women embody the neoliberal, post-feminist critical girl in their individual efforts to take responsibility for sexual health through self-education in the face of rural health disparities. However, by turning to activist community-generated queer health resources and peer-support online, participants can also be seen as rejecting neoliberal governmentality and challenging the lack of queer visibility in Tasmania.

Discussion

In this chapter, I have demonstrated how participants engage in disidentification by questioning dominant modes of sexual citizenship presented in Australian SRE. In Tasmania, high rates of STIs and youth pregnancy influence risk-based SRE that positions rural youth as sexually "risky" – a discourse participants challenged (see also Bishop 2013). All participants took issue with the inadequacy of their school-based SRE and how it shaped their understandings of sexuality and sexual health. I argue that neoliberal governmentality (embedded in public health and education policies) produces biomedical, risk-based approaches to SRE that naturalise patriarchy and compulsory heterosexuality. SRE's systemic erasure of queer women's sexualities and sexual health has negatively impacted participants' sexual self-efficacy and health literacy as young adults. The most common complaint among participants is that their SRE rarely engaged with the relational aspects and lived experiences of sex,

relationships, and gender, failing to equip them with the skills to negotiate safe sex and sexual health. Given SRE's highly limited role in the Australian Curriculum and teacher education, it is pertinent to remain critical of its capacity to bring about behavior change. In line with participants' experiences and previous research on this topic (e.g. Hillier and Mitchell 2008; Senior et al. 2014), SRE merely provides foundational understandings from a public health perspective that few students, regardless of sexuality, meaningfully internalise. Instead, as Illes (2012) argues, positioning sexuality as an essential part of citizenship and civic participation could reframe SRE as civic training for young people. I argue that this would more effectively engage LGBTIQ young people by promoting the kinds of holistic and practical information participants accessed online.

The risk minimisation discourse that dominates participants' SRE is symptomatic of neoliberal approaches to health and sexual citizenship (see Ayo 2012; Elliott 2014) (discussed in detail in Chapters 5 and 6). According to Ayo (2012: 103), neoliberal risk management strategies target the body as a site of intervention and regulation, and position the individual as a "responsible sexual agent" with a duty to mitigate their own risk by making the "right" choices (e.g. "always wear a condom," "don't hang around with certain people,") (see also Adam 2005; Elliott 2014). The "responsibilising" discourse in neoliberal approaches to public health renders personal choices, such as health-related lifestyle behaviours, as moral issues, as a means of encouraging self-regulating citizens (Adam 2005; Ayo 2012). Despite neoliberal focus on individual responsibility suggesting a gender-neutral "abstract citizen," in this chapter I have argued that notions of risk and responsibility in SRE are highly gendered (Elliott 2014: 216). Post-feminist perspectives draw on neoliberal definitions of choice, positioning women as "subjectified" sexual actors, free to make their own choices and bear the consequences of them. However, as Gill (2007: 152) points out, "only some women are constructed as active, desiring sexual subjects," with queer women, rural women, and women of colour being excluded from the white, privileged post-feminist sexual archetype (see also Butler 2013).

Participants' turn to "grass-roots" resources and knowledges shows participants disidentifying with existing structures - simultaneously incorporating, rejecting, and adapting understandings of sex and health from a critical, queer perspective. In the absence of a physical queer scene in Tasmania, Tasmanian LGBTIQ young people establish and participate in virtual queer spaces that enable them to access information and peer-support that transcends their rural situatedness. "Close-knit" small-town and rural communities foster a strong sense of place and collective commitment (see Gorman-Murray et al. 2008) that troubles neoliberal homonormativity and post-feminism, which largely apply to urban settings. Unlike post-gay analysis of LGBTIQ youth community-participation and social media usage elsewhere (see Ghaziani 2011; Holt 2011; Reynolds 2009), for the participants in this study, Tasmanian virtual communities often do translate into "real world" activism and social meet ups. By engaging in these spaces, participants are able to construct identities and challenge the lack of queer visibility in Tasmania. Therefore, my participants problematise the metropolitan heteronormativity of the ideal post-feminist sexual citizen implied by SRE and, in doing so, disidentify with dominant notions of (hetero)sexual citizenship. These findings also reveal the urban-centricity of the concept of homonormativity because in rural Tasmania creating and sharing queer knowledge and space importantly contributes to building visibility and acceptance. I argue that participants' engagement in these spaces is demonstrative of disidentification because even though they work reflexively with post-gay ideologies, here they also critique these through establishing queer knowledge and collective identities online.

In Chapter 3, I argued that participants draw on neoliberal, post-feminist discourses to position themselves as individuals ("no different from anyone else") for whom identity politics are unnecessary and minoritising. In this chapter, participants' complaints about the heteronormativity of their SRE problematise their positioning as abstract, neutral citizens. In the SRE classroom they were different from everyone else. How can the women claim "ordinariness" and attest that their sexuality is "no big deal," while concurrently challenging the heteronormativity of SRE? Although participants incorporate

aspects of neoliberal, post-feminist, and post-gay discourse into their perspectives, particularly in terms of individualism and responsibility (see Adam 2005; Elliott 2014), they also demonstrate some elements of liberation rhetoric in their critique and rejection of compulsory heterosexuality in SRE and their commitment to peer support. I argue that this is an example of Muñoz's (1999) disidentifications because rather than being "good subjects" who accept and identify with existing structures, or "bad subjects" who reject these structures entirely, participants re-engage with SRE in critical and constructive ways in order to incorporate queerness. As I outlined in Chapter 3, participants' disidentifications with homonormativity and post-feminism indicate a critical shift beyond contemporary post-feminist sexual citizenship, perhaps signaling a new queer post-post-feminism.

In the next chapter, I consider the implications of participants' SRE for practically negotiating "safe sex." I will argue that neoliberal post-feminist discourses are deployed in participants' discussions of safe sex and sexual health, while being simultaneously complicated by their experiences of rural queerness.

Chapter 5: Negotiating Safe Sex

Introduction

In the previous chapter, I explored how school-based SRE contributed to participants' understandings of sex and sexual health. I found that participants' SRE was framed within a neoliberal perspective that focused on biomedical risk, disregarded the social aspects of sex, and implicitly reproduced compulsory heterosexuality. Given their lack of access to LGBTIQ-inclusive SRE, participants supplemented the information provided to them in school with online resources.

Building on these findings, in this chapter, I consider how the understandings participants gained through SRE shape their lived experiences of negotiating "safe sex" as young adults. I argue that while neoliberal post-feminist notions of the "good" sexual citizen position young women as rational, (hetero)sexual actors, able to actively negotiate safe sex with men as equals, gendered sexual scripts complicate queer young women's abilities to embody and perform this "good" sexual citizenship, causing a process of disidentification (Muñoz 1999).

Despite strong emphasis on safe sex in youth health promotion in Australia (for an overview, see Powell 2007), as Bourne and Robson (2009) argue, meanings around what constitutes "safe" sex are often unclear or deeply subjective. As I discussed in Chapter 1, neoliberal notions of "good" sexual citizenship centre on individual civic responsibility, for example, initiatives to maintain global health emphasise the need for citizens to be active health consumers by taking personal responsibility for safer sex and seeking regular sexual health screening (see Evans 1993; Hubbard 2001). In light of this, Richardson (2005: 518) argues that "good citizenship is increasingly constituted through the voluntary governance of the self." In reflexive post-modernity the dismantling of traditional social structures renders individuals increasingly responsible for managing their own "choice biographies" in an uncertain socio-political climate where increased choice produces a heightened sense of risk (Beck 1992: 89; see also Giddens 1991). Post-feminist governmentality flourishes in this context, with young

women being particularly bound by what McRobbie (2009) refers to as the "new sexual contract" – an individualising pressure to perform "active, ideal neoliberal subjectivity" under the guise of "empowerment." In this context, making the "right" sexual health choices has become a moral imperative for young women in the West (Burkett and Hamilton 2012).

In this chapter, I examine how Tasmanian queer young women understand safe sex and how they rationalise their experiences of managing "risky" or "unsafe" sex in order to uphold their sense of being "good sexual citizens." In the first part of this chapter, I examine how participants conceptualise safe sex, drawing on their understandings discussed in Chapter 4. In the following two sections, I analyse participants' experiences of negotiating safe sex with partners of different genders and how these shape their understandings of sexual citizenship. As in the previous chapters, I use Muñoz's (1999) disidentifications to analyse how participants simultaneously identify with neoliberal modes of "good" sexual citizenship while also complicating these through their experiences of queerness. Despite presenting themselves as assertive, responsible sexual actors with men, the women employ a number of strategies to explain their lapses in safer sexual practices particularly with women. I will draw on Bloor's (1995) "situated rationalities" (see also Bourne and Robson 2009) to argue that participants construct meanings around safe sex as part of their performances of post-feminist sexual citizenship. In other words, the ways in which the women approach safe sex are not shaped by rational knowledge alone, but a complex assemblage of neoliberal values and gender norms.

Conceptualising "Safe Sex"

Australian sexual health promotion, practices, and treatment are situated in the larger rhetoric of neoliberal governmentality (see Adam 2005; Ayo 2012; Gagnon et al. 2010; Leahy 2014). Foucault (1979) describes governmentality as a complex system of institutional power relations through which societies maintain social order and functioning (see Gagnon et al. 2010). Public health campaigns play a significant role in social governance because they disseminate

and promote state-approved knowledge, norms, and social practices designed to regulate sexual conduct (Adam 2005; Gagnon et al. 2010; Leahy 2014). Neoliberal approaches to public health promote rationality and self-governance through their emphasis on making "informed, healthy choices" (Lupton 1995; Shannon 2016). As I argue in this chapter, promoting sexual health through the practice of "safe" sex is imbued with neoliberal risk-management discourse that moralises "healthy" behaviours as the "right choice" and compels individuals to take responsibility for personal risk (Leahy 2014: 174; Thorogood 2000).

In neoliberal public health discourse, safe sex is largely positioned as a biomedical concept, with dominant definitions centring on the prevention of infection and unplanned pregnancy through the use of barriers during (hetero)sex. For example, the British Department of Health defines "safe sex" as "any sex that does not allow an infected partner's blood, semen, pre-ejaculatory fluid, or fluid from the vagina to get inside the partner's body" (Bourne and Robson 2009: 284). Similarly, the New Zealand Ministry of Health (2015) describes "safe sex" as "using condoms during vaginal, oral or anal sex with every partner, every time." These definitions often emphasise the role of condoms in protecting individuals from infection and for preventing pregnancy, where safe sex is synonymous with "protected" sex.

Aligning with the neoliberal imperative to take responsibility for practicing safe sex, I wanted to explore how participants conceptualise safe sex and how these understandings shape their behaviour. When asked to define what safe sex means to them, 14 of 15 participants' first responses adhered to neoliberal, biomedical definitions.

> Using protection, like, not getting pregnant and not getting STIs. You know, that sort of thing. (Jayden, 20, pansexual)

> Making sure you use the right kind of protection, depending on… what you're doing… and there's always just the standard hygiene things… around sex… to prevent UTIs and that sort of stuff. (Carrie, 23, bisexual).

> All the stuff… wearing, you know... protection and making sure, you know... blah blah blah… all that stuff… (Middy, 19, fluid).

The predominance of biomedical understandings of safe sex among participants reflects how neoliberal governmentality shapes sexual citizenship. As outlined in Chapter 4, positioning SRE in the Australian Health and Physical Education curriculum is a mark of neoliberal governmentality. This enables young people to be socialised to perform "healthy" and "good" citizenship (Ayo 2012: 100). Despite complaints documented in the previous chapter that their SRE was too biological, medicalised, and heteronormative, participants adopt these understandings as their primary way of approaching safe sex. The notion of safe sex as synonymous with protection is so commonly held that participants speak about it as if it has been learned by rote ("blah blah blah… all that stuff…" "that sort of thing"). Middy and Jayden's frequent utterance of "you know" reinforces the dominance of biomedical definitions, as they assume consensus as to what safe sex is. Carrie's comment about "just the standard hygiene things" is also demonstrative of participants' attempts to position themselves as knowledgeable sexual citizens by adopting medicalised language when discussing sex and demonstrating "standards," or, shared understandings of how to practice safer sex.

Participants' biomedical understandings of safe sex align with neoliberal rationality as they focus on risk management through individual regulation and control (Ericson et al. 2000). Both Middy and Carrie use the phrase "making sure" in their definitions, emphasising individual responsibility for managing sexual health outcomes. This approach assumes a rational actor model, with participants believing that their knowledge and understanding of "the standard hygiene things around sex" implies an ability to then make the "right" sexual choices (Farrelly et al. 2007: 66). These positionings reflect post-feminist representations of young women, who are frequently presented in SRE and public health discourse as responsible, entrepreneurial health citizens (Wiklund et al. 2010: 1568). For example, Australian youth public health campaign slogans

(e.g. “tell him if it’s not on, it’s not on”) often position women as being responsible for heterosexual safer sex (see Burkett and Hamilton 2012; Powell 2007), while similar promotion for breast screening and HPV and pap smear awareness imply an active, feminine health entrepreneur.

However, as health sociologists observe (e.g. Bishop 2013; Bourne and Robson 2009; Lupton 2013), biomedical explanations and directives for practicing safe sex (e.g. “use a condom every time”) often disregard the gendered, social factors underpinning sexual behavior (see Amaro 1995; Bourne and Robson 2009; Curtin et al. 2011; Hillier et al. 1999). Subsequently, more holistic definitions of safe sex incorporate messages about “healthy relationships.” For example, the Tasmanian Department of Health and Human Services (DHHS) (2005) defines safe sex as being “all about looking after yourself and your partner. It is about avoiding unwanted pregnancy, reducing the risk of STIs, and staying emotionally healthy.” While this definition incorporates medical risks, it applies the social model of health to the notion of sexual safety, recognising the structural factors that shape sexual experiences, the importance of the context in which sex occurs, and the lived implications of unsafe sex.

Although participants widely accept biomedical approaches, they also have holistic, social understandings of safe sex. In Chapter 4, a common complaint among participants was the lack of recognition of the gendered, social factors influencing the negotiation and experience of safe sex. Subsequently, 13 participants discuss the importance of mitigating emotional or social risks as well as the physical/medical risks during sex. For example:

> I think one of the main things about safe sex that I’ve been thinking about the most lately is actually about respect, trust, and consent. Cause, you know, the things that scare me the most about sex are not pregnancy or diseases... but... respect. Um… having a psychologically healthy relationship with sex and with your sexual partner. And psychological health will equal physical health, because it means that you’re taking adequate care of yourself in regard to protection. (Evie, 26, pansexual)

> I think consent encompasses most of it… Because it means like... consenting to using this much protection, or in some cases maybe no protection. And then... doing things that all parties are comfortable with and are agreeing to. I think it's just making sure everyone's informed about and agreeing to what's going on. Um, that you have a relationship, or relationships, that are built on trust and are built on doctor's visits (laughs) (Isabelle, 21, queer).

In response to their impractical SRE, participants emphasise the importance of framing safe sex as a negotiation, which ten women see as a political, feminist act. Sexual consent has long been an important concept for feminist activists and scholars because of its pivotal role in sexual violence discourse and prevention (see Beres 2007; Burkett and Hamilton 2012; Carmody 2009; Firth and Kitzinger 1997; Gavey 1991; Mackinnon 1989; West 2002). In their discussions of the importance of consent, participants draw on feminist rhetoric ("no means no," "consent is sexy," "my body, my choice") to illustrate its significance for building sexual self-efficacy (see also Curtin et al. 2011). Evie differentiates her feminist concerns about the role of "respect, trust, and consent" in negotiating safe sex from the more commonly discussed biomedical risks ("pregnancy or diseases").

However, rather than being entirely subversive, I argue that these participants' emphasis on consent is an articulation of post-feminist sexual citizenship. While the women's "holistic" definitions of safe sex engage with the social context of sex, they still invoke neoliberal messages that prioritise individual responsibility and dissuade critical examination of sexual and gender inequalities. Although Evie and Isabelle express feminist sentiments in their emphasis on consent, their framing is arguably situated in a post-feminist "empowerment" paradigm that focuses on individual (women's) responsibility for safe sex. Some feminists problematise popular consent discourse by questioning the extent to which women can "freely" consent in patriarchal systems that shape and constrain their choices (see MacKinnon 1986). Similarly, as Burkett and Hamilton (2012) observe, although post-feminist discourse positions consent as empowering for

women, this disregards how gendered sexual scripts constrain women's abilities to negotiate consent, causing women to consent to unwanted or unpleasant sex.

For Adam (2005: 339), the notion of informed consent is a core aspect of neoliberal individualist rhetoric that stresses personal responsibility and contractual interaction. To illustrate, Isabelle mentions the importance of "taking adequate care," or responsibility, for protection, and "making sure everyone's informed and agreeing to what's going on." This is a neoliberal framing as partners are established as "informed," responsible and equal sexual actors, even in cases that some may deem "unsafe" (e.g. "in some cases, maybe no protection.") Isabelle positions herself as a post-feminist "critical girl" who reflexively engages with popular feminist notions of consent, while simultaneously advancing neoliberal ideology (see Harris and Dobson 2015). In line with this perspective, Jackson and Weatherall (2010: 180) suggest that post-feminism's sexually empowered "new femininities" may afford young women fleeting opportunities to "undo" hetero-patriarchal gender norms by repositioning the role of feminine agency in safe sex through the active negotiation of consent (see also Harris and Dobson 2015).

However, I argue that post-feminist consent rhetoric is unsuccessful in undoing hetero-patriarchal gender norms because of its inherently neoliberal focus, which fails to account for intersecting, structural inequalities. As white, middle-class, educated young women, participants' post-feminist understandings of safe sex reflect their socio-economic privilege. Evie and Isabelle's accounts evoke neoliberal governmentality and healthism through the integration of health consumption in their definitions of safe sex - Isabelle describes a safe and "healthy relationship" as one that is "built on doctor's visits." This ability to reflexively navigate consent, to be "informed," and to negotiate relationships "built on doctor's visits" is profoundly raced and classed. As Skeggs (2004) and Mulinari and Sandelll (2009) outline, the neoliberal prioritisation of the reflexive self ignores the economic, social, and cultural capital involved in navigating Beck and Beck-Gernsheim's (1995) "choice biographies." Therefore, class privilege and whiteness play a role in participants' abilities to reflexively negotiate choice

and consent to unprotected sex with men. The neoliberal focus on individual responsibility underpinning participants' understandings of safe sex divorces individuals' intimate lives from broader power structures, erasing inequalities in healthcare access and gendered sexual politics in favour of post-feminist choice narratives. These findings suggest that a complex assemblage of (post)feminist and neoliberal ideologies influence participants' understandings and experiences of safe sex.

However, in the next section, I show how participants' lived experiences of negotiating safe sex do not always directly align with their rational understandings. Gendered sexual scripts play a significant role in influencing participants' abilities to negotiate safe sex and their contextual perceptions of risk. These gendered perceptions of sexual risk are important in establishing how participants construct meaning around safer sex with partners of different genders.

Negotiating Safe Sex With Men

When discussing their understandings of safe sex, participants' initial responses were based on their past heterosexual experiences. This reflects the compulsory heterosexuality of mainstream sexual health promotion for young women and the predominance of heterosexual safe sex scripts. As I discussed earlier, safe sex discourse is largely based on the assumption of rational decision-making, which fails to account for the unequal gendered power relations at play during heterosex (see Allen 2005; Amaro 1995; Farrelly et al. 2007; Hillier et al. 1999). In this section, I explore how (hetero)sexual scripts shape participants' experiences of negotiating safe sex and risk. Despite establishing themselves as empowered sexual actors, participants' attempts to negotiate safe sex with men are constrained by gendered sexual scripts that privilege men's sexual pleasure and emphasise women's responsibility for sexual risk management.

The SRE that participants received was heteronormative and largely risk or problem-based. For participants, this results in approaches to safe sex that focus

on heterosex and risk management. Post-feminist, neoliberal governmentality targets women's bodies as sites of intervention and regulation, whereby individual bodily control is internalised as a duty of responsible health citizenship (Ayo 2012: 103; Gill 2007; Lupton 2013). Given this context, participants are hyper-aware of the imperative to take responsibility for ensuring safe sex. Accordingly, when asked how they approach safe sex with men, participants portray themselves as responsible, health-literate sexual citizens who communicate effectively with partners and seek regular sexual healthcare:

> I've always been really kind of over anxious about making sure that everything's going to be good and that... like people are 100 per cent into it and consent is a big thing…and that sort of thing…And…um, like obviously... getting STI checks if... I sleep with someone new… And…Um… yeah like making sure they do as well if it's going to be unprotected etc, etc…(Jayden, 20, pansexual).

> I've been pretty lucky that I haven't always really had to explicitly negotiate it [safe sex], except for being like "you're using a condom, right?" and they'll be like "yeah." Cause…I'm fairly good at communicating….I get tested all the time and I make sure he does as well… (Isabelle, 21, queer).

> I'm…fairly…I'm very strong in...what I want to do and what I don't want to do, so I've got no hesitation about bailing out on something, if it's not...um...going well...I never feel like I have to do something, and I'm not afraid to ask like…about STDs…or...making sure he's using a condom or…anything like that (Carrie, 23, bisexual).

These accounts demonstrate participants' identification with established models of "good" (neoliberal, post-feminist) sexual citizenship. As in Beck's (1992) view, an "over anxious" approach to all aspects of contemporary life, but especially sex and intimacy, is a product of post-modern risk and reflexivity. Participants'

descriptions of their "over anxious" approach to negotiating safe sex is characteristic of a post-feminist sensibility, emphasising individual responsibility, health consumerism, and bodily control (Gill 2007). For example, Jayden demonstrates this sensibility through the use of phrases like: "that sort of thing," "obviously" and "etc. etc." suggesting that she believes these approaches are common knowledge, or unquestioned steps of good sexual practice. Isabelle's comment that she has never had to explicitly negotiate safe sex with partners also demonstrates the extent to which safer sexual practices are incorporated or routinised into established (hetero)sexual scripts. Like Jayden, Carrie and Isabelle portray themselves in line with post-feminist models of sexual empowerment, demonstrating their ability to assertively negotiate safe sex with men. By emphasising the importance of seeking her own STI checks and "making sure" partners get checked, Jayden positions herself as not only an active health consumer but an assertive sexual partner who instructs others to seek sexual healthcare responsibly.

In line with the focus on heterosexual reproduction in SRE at school, while there is some concern about STIs, 12 out of 15 participants see contraception as the main purpose of practicing safe sex.

> It's always BABIES! It's always the risk of pregnancy that worries me the most. Like I've never… never kind of like… In times when I have not been as careful as I could be, particularly in my past, I never thought "Oh Gosh! He could be giving me a disease!" It's always been more like "Oh God! I could get pregnant here..." I really think that… like in terms of contraception… the onus is on women to not get pregnant… (Stella, 26, bisexual)

> Definitely always using protection. Like, in high school… when you're taught about safe sex and everything you're taught… You Have to use a condom! Penis is evil! Gunna make you pregnant! Gunna give you diseases! You have to use protection! (Miki, 25, bisexual)

> It was definitely always just assumed that safe sex equals not getting pregnant. Like, I was taught… Penis goes in, gunk comes out. That gunk's gunna get you pregnant… and ruin your life. Like, the biggest risk to a teenage girl's existence was pregnancy. (Pip, 20, pansexual)

In a post-feminist climate where the ideal young (white, middle-class) woman is portrayed as a responsible and informed sexual subject, unintended pregnancy is positioned as an individual failing resulting from personal irresponsibility or "poor choices" (see Curtin et al. 2011). These extracts reveal participants' privilege, as other issues like STIs and sexual violence are less concerning to them. In Tasmania, intergenerational socio-economic disadvantage, poor health literacy, reduced healthcare access, and high rates of youth pregnancy mean that many young women do not have the ability to reflexively negotiate choice and risk in the way that these participants do. However, their emphasis on pregnancy is also a product of this environment, as they are profoundly aware that getting pregnant would alter their lifecourses negatively as white, university-educated young women considering their career prospects in a state with high youth unemployment and limited job opportunities. Here, both post-feminist neoliberal risk discourses and the specific Tasmanian socio-economic context shape participants' experiences of gendered sexual citizenship.

As Powell (2007) outlines, youth sexual health promotion routinely reinforces the gendered sexual script of feminine responsibility for safe sex ("the onus is on women to not get pregnant"), with young women positioned as responsible gatekeepers tasked with regulating young men's "uncontrollable" masculinities (see also Burkett and Hamilton 2012; Elliot 2014; Senior et al. 2014). However, unlike the ideal post-feminist sexual citizen represented in youth health promotion, participants find it difficult to negotiate safe sex with men despite their initial descriptions of themselves as assertive sexual actors. Subsequently, the women seek to perform "good" neoliberal sexual citizenship by balancing responsibilising discourses with their lived experiences of sex and risk. For example:

> In having heterosexual sex, it has always kind of been me who's like enforced safe sex, like… it has always been me… like it's the woman's job to enforce safe sex because we're the ones left with the consequences of it… I mean, obviously with guys… you expect them to… be prepared, I suppose… They've almost always been like "yeah yeah fine, put a condom on, whatever" but it's always my idea to… Like, it's always my suggestion, like: "Do you have a condom? Do you have something?"…But at the same time, if they're not prepared I haven't said no… It's a bit awkward. A lot of guys I've been with have just assumed that it would be OK not to use anything. (Miki, 25, bisexual)

> Like, a while ago when I wasn't like totally in the right mental space to...actually…(laughs) make the right decisions and… I was a bit risky and, ah, I slept around a bit, I guess…I think guys kind of just took advantage of that…But…I'm a bit ashamed. Anyway…I…ended up getting tested and it was all fine… and I learned from it and…yeah. (Middy, 19, fluid).

> Then I was an idiot and slept with a few people when…like at 3am while I was drunk and didn't ask questions (laughing). It was just… like… I was so tired, I forgot that condoms existed and that they were a thing you that you should use… (laughs) but…(quickly) I got checked after that and I was fine…(laughs) so that was good. (laughs) (Jayden, 20, pansexual).

These experiences illustrate Bloor's (1995) concept of situated rationalities, a process whereby individuals make sense of sexual risk by (re)constructing alternative understandings and definitions of risk and safety through their lived experiences (see also Bishop 2013; Bourne and Robson 2009). Given the social desirability of safe sex and being a good sexual citizen, participants are often embarrassed to admit their "risky" behaviour. To mitigate this, they laugh nervously and invoke situated rationalities to diffuse risk by emphasising their responsible health seeking behaviours following unprotected sex (Bourne and Robson 2009). Participants' ambivalence to lived experiences of unsafe sex ("I haven't said no," "I forgot that condoms existed") is at odds with many of their

earlier portrayals of themselves as "over anxious," vigilant and responsible sexual citizens. Such experiences indicate that the negotiation of safe sex is not always a rational agreement between equals.

By emphasising their culpability for the lack of negotiation in situations of risk ("I'm bit ashamed," "I was an idiot," "I haven't said no"), participants reproduce the sexual script of feminine responsibility. As in Wiggington et al.'s (2016) study of Australian women's use of contraception, participants perform feminine sexual citizenship through their contraceptive practices. As Miki explains, most of her male partners believe it is acceptable to not use condoms, as they assume women are taking the contraceptive pill. In Miki's framing, hormonal contraception is a post-feminist technology of the self that forms an important part of performing neoliberal sexual citizenship. For eight of the participants who either currently use hormonal contraception or have done so in the past, the Pill is a means of being available for sex while still being able to mitigate pregnancy risk (see also Wiggington et al. 2016: 730). However, as someone who cannot use hormonal contraception for medical reasons, Stella finds these sexual scripts difficult to navigate:

> Because I can't have... the... I can't have any of the… pills or the injections... the shots or anything... so we have to use condoms all the time. And I'm always apologising, I'll say "I'm so sorry, I'm so sorry" because I can't have any of the… current medical treatments for it… It is something I do feel very guilty about. Because I feel like I might be taking something away from him... Like... I might be denying him that extra percentage of… pleasure for him and I feel like I've constantly got to apologise. But I've got a friend who's like similar to me and I'm always on at her about it, because she's like the same as me, she gets really bad reactions, and she never makes her lovers wear a condom... because that will annoy them.

Stella's guilt about her perceived failure to adhere to sexual scripts that assume hormonal contraceptive use further demonstrates the feminine responsibility narrative of safe sex. In contrast to her friend, Stella positions herself as a

responsible sexual citizen, insisting on the use of condoms, despite being aware that this may "annoy" partners – or, contravene gender norms. Here, negotiating safe sex with men involves a complex navigation of sometimes competing gendered sexual scripts that can make achieving positive sexual health outcomes for young women difficult. Curtin et al. (2011) argue that "femininity ideology," or the hegemonic norms of "acceptable womanhood," diminishes women's sexual self-efficacy and health literacy, making them less equipped to actively negotiate safer sex with men, despite being positioned as responsible. Similarly, for participants in this study, the gendered sexual script of feminine responsibility is at odds with hetero-patriarchal gender norms that position women as sexually receptive, making it difficult for women to "just say no" to unsafe sex (Wiggington et al. 2016). These inconsistencies are common among participants, suggesting that ideal neoliberal post-feminist sexual citizenship involves a gendered set of organising principles for how women should see sex that does not translate as seamlessly in practice. Therefore, the neoliberal assumption that health inequalities are the result of "poor choices" fails to recognise how broader structural factors shape individuals' abilities to act.

As demonstrated in the quotes above, when discussing experiences of "risky" or unprotected sex, participants re-establish themselves as good sexual citizens by emphasising risk reduction alternatives to rationalise their experiences (see Cox and McNair 2009). "Getting tested regularly" is a common strategy used to rationalise unprotected sex:

> I've never been careful with oral sex … but... um… but I get tested for sexually transmitted diseases every year, so... (Evie, 26, pansexual)

> Yeah, but, I get tested all the time, so… (Isabelle, 21, queer)

> I'm not afraid to ask, like… about STDs… and I always get tested so, stuff like that… (Carrie, 23, bisexual)

These participants justify taking the risk of contracting STIs through unprotected sex by emphasising their regular sexual health checks. By rationalising these experiences of medical risk with the common refrain of "getting tested regularly" participants position themselves as responsible, self-regulating sexual actors and active neoliberal health consumers. In many cases, testing itself is seen as a reliable risk reduction strategy among participants, with many women approaching STIs as easily fixed by early medical intervention.

> If you've got herpes you've got herpes forever, but it's never gonna kill you… like it's a manageable thing… If you've got Chlamydia you can get rid of it… If you've got Gonorrhoea you can get rid of it… and that's the thing, because I get check ups so regularly, if I do find that if I have something like that it's easy to deal with… (Sloane, 26, queer)

While participants seem confident that "getting checked regularly" portrays them as good sexual citizens, this is a reactionary approach to risk, rather than a preventative one. However, participants' emphasis on testing can be interpreted as an act of regaining control of situations where they have been unable to actively negotiate with men due to the gendered power dynamics at play in dominant sexual scripts (see also Burkett and Hamilton 2012). As Sloane's account illustrates, participants are pragmatic about STI testing and treatment, neutralising the risks of unprotected sex by emphasising the perceived ease and effectiveness of STI treatment. This approach is demonstrative of participants' privilege - as largely white, middle-class, university educated, health literate, young women without physical disabilities, most participants have access to primary healthcare in Tasmania. Overall, because of their ability to access comprehensive care for (hetero)sexual health, a common situated rationality is to emphasise screening as an "easy fix."

In the next section I explore how participants experience safe sex and risk with female partners. I argue that an absence of established sexual scripts makes it difficult for women to even conceptualise queer safe sex.

Negotiating Safe Sex With Women

When it comes to discussing safe sex with female partners, few participants even know where to start. In this section, I examine how participants understand safe sex with women, arguing that the heteronormativity of safe sex discourse renders queer safe sex unintelligible, causing women to "disidentify" with their previously described modes of "good" (hetero)sexual citizenship. I argue that due to a lack of knowledge and absent sexual scripts, queer young women face difficulties negotiating safe sex with female partners, indicating a need for improved community awareness and relevant public health promotion targeting queer young women. I argue that the positioning of lesbian sex as not "real," and therefore not "risky" has negative implications for queer young women's abilities to negotiate safe sex (see also Cox and McNair 2009; Power et al. 2009). Developing greater awareness of queer women's risk reduction strategies beyond heteronormative frameworks is important for establishing a culture where sexual health, risk, and testing are discussed more commonly among queer young women in regional and rural Australia.

When asked how they understand and negotiate safe sex with women, the same participants who previously established themselves as responsible (hetero)sexual actors who are "good at communicating" responded with disproportionate vagueness:

> It's just not something that gets talked about… (Isabelle, 21, Queer)

> It just hasn't been discussed, basically… Yep. Just… Don't even really consider it really. (Miki, 25, bisexual)

> It's just... it's never been a thing... It was never discussed. Never thought of in the moment. It's just… just not… (Stella, 26, bisexual)

In line with previous Australian research (see Cox and McNair 2009; Power et al. 2009; Richters et al. 2010), these participants' responses reflect an absence of

language with which to negotiate safe sex with women. In stating, "it's just not something that gets talked about," Isabelle assumes that discussing safer sex is not a common practice among the broader community of queer women (see Richters et al. 2010). Due to the heterosexist centrality of penetrative sex in sexual health promotion and in culture more broadly, sex between women is commonly positioned as not being "real" sex (see Cox and McNair 2009; Logie 2014; Power et al. 2009: 78). While global rates of STI and HIV transmission between women are low, women who have sex exclusively with women are still at risk of contracting a range of STIs, such as HPV (Ferris et al. 1996), Herpes (Marrazzo and Stine 2003), and Bacterial Vaginosis (Marrazzo et al. 2005). Despite this, there has been a dearth of Australian health promotion material specifically targeting queer young women, resulting in a lack of established safer sexual scripts within these communities (see Power et al. 2009).

The absence of safer sex discourse for queer women is reproduced through biomedical approaches that focus solely on heterosexual, penetrative sex as a source of risk for women (see Logie 2014). Like Scherzer's (2000) participants, participants in this study are critical of biomedicine and do not approach queer safe sex in the same medicalised manner as with heterosex. As outlined in the previous section, while participants primarily conceptualise safe sex as "protected sex", this biomedical, risk-based approach does not appear in their understandings or practice of safe sex with women. Although all participants are aware of barriers (e.g. dental dams, gloves) that are recommended for preventing fluid exchange between women, none have previously used them, and only three report considering using them in the future (see also Cox and McNair 2009; Power et al. 2009; Richters and Clayton 2010; Richters et al. 2010). Participants justify this avoidance through lack of established sexual scripts, perceived undesirability and/or inconvenience, and previous lack of awareness.

> I guess I can see using gloves in my future sexual practices but… Then again, like… carrying around gloves in your purse just in case seems like a weird thing to do! (laughs) Like, kind of creepy! And how would I bring that up? Like, the girl's going to think I'm implying she's dirty or

> something or… I dunno… It's just not something you think of… "I'm just going to put on my gloves now" like what!? (laughs) (Sloane, 26, queer).
>
> I only found out about dental dams recently, so, um, yeah, I've never used them and…I don't really think I would. They seem a bit…gross, really. Not something I would (laughing) purchase! Imagine pulling one of those out! (laughs) No. (Carrie, 23, bisexual).
>
> That kind of thing hasn't ever really come up with girls. Like, how would I…? I don't know what I'd say… (laughing) No. Nup. They'd just take all the fun away. I was actually given [a dental dam] at [a queer event] recently and I read about what it was and I was like, cool, but I'm not using one of these – straight in the bin. (laughs) (Stella, 25, bisexual).

In recent decades, global efforts have been made to establish and encourage sexual scripts that involve the negotiation of safe sex among heterosexuals and gay men. For example, Philpott et al. (2006) describe the eroticisation of condom use in Western health promotion during the HIV/AIDS crisis as a means of normalising safer sex. These initiatives have largely been successful, with Australian young people's rates of condom use during their first sexual experiences increasing compared with older generations (De Visser et al. 2014). Furthermore, language around condom negotiation is now routinely used in sexual health campaigns targeting youth. In contrast, the extracts above demonstrate that the use of barriers has not been as successfully integrated into safer sexual scripts for Tasmanian queer women ("how would I bring that up?" "I don't know what I'd say"), making it more unlikely and difficult for young women to actively negotiate their use. It is possible that women avoid talking about "safe sex" practices with female sexual partners because doing so would imply that partners are not "clean" ("the girl's going to think I'm implying she's dirty or something"). In contrast, it may be easier for women in this study to have such conversations with male sexual partners because condoms are directly linked to preventing pregnancy and/or STIs and therefore, their use

allows women to circumvent any discussion of men's cleanliness.

Indeed, while participants all acknowledge that some precautions are needed when having sex with women, few believe these to be pressing concerns because of their heteronormative understandings of sexual risk. Therefore, when discussing their experiences of negotiating safe sex with women, participants maintain their sense of what it means to be a "good" (hetero)sexual citizen, while rationalising their lack of safer sexual practices. As in their experiences with men, participants deploy neoliberal situated rationalities that stress their knowledge and willingness to accept the consequences of their sexual "choices" (see Adam 2005). Through these understandings of safe sex, participants aim to balance their low perception of risk with their desired outcome of satisfying sex with women (see Bourne and Robson 2009). Participants draw on gender stereotypes that position women as inherently safer sexual partners than men:

> I kind of just assume… that women are more in touch with their bodies and that women are more honest and they would tell me… (laughs) I assume a lot more about women being good people when it comes to that sort of thing… (Evie, 26, pansexual)

> With women… it's a lot less… You know, there's less hand-washing and less being… you know... You're just less, like… It's a lot more spontaneous and you don't have to think so much about it, because there are no repercussions. I mean I've always been with people who have said they've been checked and that's all good… I guess I just trust them. But I've never bothered to get checked when I've been with girls cause… I just reckon they'll be fine. (Max, 21, bisexual)

> I don't think of guys as being particularly clean. I kind of think of women as being cleaner… I assume that they would know... they would be more aware of their sexual health and that it would be safer in that context because… I don't know… I just think of women as being cleaner human beings. (Sloane, 26, queer).

Here, participants rationalise their lack of safer sexual practices with women by positioning women as safe and clean. Assumptions about women being "cleaner" and "more in touch with their bodies" reflect gender stereotypes of femininity as being associated with the body and allude to gender roles that place higher expectations on women to engage in bodily maintenance and control. Post-feminist sexual scripts that emphasise the need for women to be responsible, embodied sexual actors inform these gender stereotypes that participants have internalised. Because participants see women as cleaner than men, there is a common sense of women being inherently more trustworthy ("I assume a lot more about women being good people"), therefore the need for testing after unprotected sex with women is also perceived to be low.

Given their scepticism of biomedical approaches to safe sex with women, these participants are more likely to engage in risk-reduction alternatives to latex-based safer sex practices, such as relying on trust and maintaining good general hygiene (see also Cox and McNair 2009). By stating that "there's less hand-washing," Max may simultaneously be referring literally to the medicalised hygiene and healthism around heterosexual safe sex, but also to the labour of risk management that young women are expected to engage in as responsible (hetero)sexual citizens. Participants' aversion to latex-based safer sex practices for women arguably stems from its lack of integration into established queer sexual scripts (see Cox and McNair 2009: 16; Power et al. 2009). In light of this, MacBride-Stewart (2004) argues that dominant understandings of "healthy sex" largely exclude queer women, with dental dams acting merely as a symbolic mechanism for containing the lesbian body (see also Richters and Clayton 2010: 104). While dental dams have been symbolically portrayed as "the lesbian answer to the condom," no studies have provided empirical evidence for their effectiveness in preventing STI transmission or the prevalence of their use (see Richters and Clayton 2010; Richters et al. 2010). Furthermore, despite lesbian sex being positioned as "safe," dams and gloves are paradoxically never recommended for the same sexual practices between men and women. This suggests that sexual health promotion targeting queer women would be more

effective if it were to engage with women's lived experiences and negotiations of risk reduction rather than focusing on the medicalised, heterosexist symbolism of latex barriers.

Although participants are unlikely to practice unprotected sex with male partners if they are unclear of their sexual history and health status, many participants are more trusting of women. Here, although participants portray themselves as responsible sexual citizens who get tested regularly in the context of heterosexual sex, participants' adopt alternative strategies to manage and rationalise risk with women. Trust is commonly invoked as a way of managing safer sex with women (see also Bishop 2013; Bourne and Robson 2009). For example, Carrie only has sexual relationships with women she already has an ongoing relationship with:

> I have been… Really slack. Like, in terms of using condoms and that sort of thing… with women… but... The two that I have been with have both been really good friends of mine, so … I dunno… It's weird how like if it's your friend its like 'oh, it's fine.' Cause I trust them.

Previous studies have similarly found that the symbolic significance of sex is gendered, as women are more likely to emphasise the importance of trust as a sign of sex being safe (see Bourne and Robson 2009; Hillier et al. 1999). As Carrie demonstrates, the sense of safety that trust and familiarity instils has the ability to override any medical safety concerns that may exist (see also Bourne and Robson 2009: 288). Max similarly illustrates this point when she neglected preventative screening after unprotected sex with women ("I guess I have to trust them," "I reckon they'll be fine"). According to Pilkington et al. (1994: 204), people with more positive feelings towards their partners experience reduced perception of sexual risk and are then less likely to use protection, which they describe as the "halo effect." Participants' assumptions that women are generally "good people" and are therefore "cleaner" and more trustworthy than men can be similarly interpreted as a result of this halo effect. While Carrie recognises an obligation to conform to medicalised standards of good sexual citizenship ("I

have been… really slack"), she juxtaposes this with her lay understandings of managing sexual risk that centre more on the social factors like trust. Therefore, because participants have different understandings of risk in the context of sex with women, these inform alternative approaches to safer sexual practice.

Participants often express guilt when admitting their lack of safer sexual practices with women. Such sentiment indicates a sense of obligation to adhere to neoliberal standards of healthism that place responsibility on citizens to be self-determining health consumers. However, Evie uses an analogy that illustrates how the rational actor model assumed by healthism may not always be useful for explaining sexual health behaviours:

> I'm not just going to eat salad, because that's fucking boring! I know it's better for you… but it's boring… It's kind of like, no one wants to put a penis in a condom in their mouth! It's disgusting!! What am I supposed to do? Spread glad wrap over a pussy before I eat it? No! That's SO gross! So gross! (laughing) So, yes. That's my approach to sexual health.

Here, Evie uses imagery of plastic to evoke a sense of being sanitised or dehumanised by what she saw as excessive standards for sexual risk management. Using course language, Evie emphasises the "grossness" of latex barriers for oral sex by drawing links between using dental dams and eating plastic – something unnatural and unappealing. Furthermore, her visceral use of words like "disgusting" to describe an effectively sterilised sex act, Evie complicates the notion of "safe sex" being "clean," as here sterility seemingly removes the humanity from an essentially human act. For Evie, the intimacy of skin-to-skin contact during oral sex with partners of either gender is central to the purpose of the act, with barriers diminishing both pleasure and the sense of trust between partners. These comments are an effective exemplar of how risk discourses in public health understandings of safe sex fail. All participants similarly describe dental dams as being "unsexy" or something that would "take all the fun away." While this rejection of standardised sexual health practice may be seen as a subversion of neoliberal healthism and its "sealing" of the queer

body (see MacBride-Stewart 2004), Evie still deploys a neoliberal response through her emphasis on individual freedom of choice and responsibility for consequences of that choice (see Adam 2005).

Navigating experiences of risk is problematic for participants because the absence of sexual scripts prevents them from rationalising risk in the mode of neoliberal health citizenship to which they are accustomed. Despite positioning sex with women as inherently safe, the lack of established sexual scripts has had negative emotional implications for some participants.

> My early experiences with sexuality were pretty negative. And I think that's probably because there was no blueprint for what a relationship was meant to be when it was … between two women… there was no one who was like … You know, we'd have classes and they'd be like, you know, if a guy hits you or if a guy yells at you or … you know there's a whole set of behaviours that are identified as negative. And that's a bad relationship. (Sighs) But no one ever sits down with queer girls and says this is what, like, when a woman abuses you this is what it's like to be sexually assaulted by your girlfriend… because… That stuff isn't included in sex ed and it isn't talked about um… ever… So there was no guidance to validate the relationship, just AS A Relationship, let alone as how we want a relationship to be. Like… there was no "this is what is good. This is what boundaries mean." For bisexuals, for lesbians, for queers in general. Um. And with that comes an inability to talk about it with friends. Um. An inability to talk about it with teachers… or… Family.. because.. It wasn't a… In my mind these weren't real relationships… they were just like… Intense friendships or they were just like… you know... "exploring" or… a "Phase"… It wasn't like "This Is Who I Am and I Need Help." It was… it wasn't real… Even though I was being … I was… I was in abusive relationships… (Frankie, 25, bisexual)

Frankie powerfully evokes the detrimental implications of the absence of a "blueprint," or established norms and sexual scripts for queer women's

relationships. As I have outlined throughout this section, gendered assumptions that position queer women as "low risk" have contributed to a lack of safer sexual scripts, making it difficult for young women to conceptualise and negotiate queer safe sex. By contrasting the well-established norms around safe sex and "healthy relationships" for heterosexual young people with the invisibility of LGBTIQ identities and relationships in SRE, Frankie's account illustrates how an overemphasis on heteronormative risk discourse and feminine responsibility fails to prepare young women for navigating queer safe sex and relationships. Here, compulsory heterosexuality structurally disadvantages Frankie as a queer young woman, with the broader cultural erasure of bisexuality and queer women's relationships contributing to her difficulty negotiating safer sexual experiences. This story demonstrates how social stigma and exclusion may further contribute to poor mental and sexual health in LGBTIQ communities, as few supports exist for abuse and intimate partner violence among same-sex couples, especially for young women. This is despite the fact that studies have found high rates of intimate partner violence between women (see Mooney-Somers et al. 2014: 46). Therefore, Frankie's experience highlights a problem with neoliberal public health approaches to safe sex, as these assume heterosexuality and overemphasise individual responsibility, thereby erasing the experiences of marginalised queers.

In line with my feminist research ethics and methodology, it was important that Frankie felt acknowledged and supported in sharing such distressing personal experiences with me. Following this account, we agreed to pause the interview recording and take a moment to sit with Frankie's story. After a pause, I acknowledged that Frankie had experienced abuse and thanked her for feeling comfortable to share her experience with me. To renegotiate the boundaries of the interview, I reiterated the details about voluntary participation and informed consent on the research information sheet (see Appendices C, E). I mentioned my intent for participants to only share what they were comfortable to discuss. Hearing Frankie's story was one of the most emotionally challenging points in this research for me. However, after debriefing with Frankie following the interview and discussing the experience with a close colleague, I identified this

as a moment that has compelled my commitment to this research. While retelling her story was distressing, for Frankie, it is important to share these experiences to raise awareness of how detrimental the absence of affirming SRE and queer sexual scripts and is for young women and the LGBTIQ community as a whole.

Discussion

In this chapter I examine how neoliberal approaches to sexual health position young women as active, responsible (hetero)sexual citizens. Participants perform this "good" sexual citizenship through their safer sexual practices and health-seeking behaviours. In keeping with the post-feminist sensibility, participants emphasise their responsibility and assertiveness in negotiating safe sex with men. Because neoliberal forces obscure continuing gendered power structures under the guise of post-feminist equality, competing gendered sexual scripts complicate participants' lived realities of negotiating safe sex. The responsibilising and risk-management imperatives deployed through neoliberal SRE and public health promotion contribute to the participants' prioritisation of biomedical protection definitions of safe sex. As post-feminist "critical girls" (Harris and Dobson 2015), the participants also express concern about the social aspects of safe sex, emphasising the importance of communication and consent. However, these neoliberal approaches fail to account for the heterosexist structural constraints that impact young queer women's abilities to actively negotiate safe sex and relationships. Therefore I argue that the mainstreaming of safer sexual scripts for gay and bisexual men can be seen as a product of androcentric homonormativity (see Duggan 2002; Logie 2014), while women's queerness remains marginalised in both neoliberal and post-feminist projects.

Participant narratives of "good" (hetero)sexual citizenship are complicated by their experiences of queerness. As in previous chapters, participants disidentify with established modes of sexual citizenship, embracing alternative sexual health behaviours that accommodate queerness. Rather than representing my participants as irresponsible for not adhering to medicalised notions of safe sex, in this chapter, I explore women's own meaning making and their approaches to

managing safe sex and risk in the context of sex with women. Participants use situated rationalities to explain lack of safer sexual practices with women including the invocation of gender stereotypes and neoliberal responsibilising rhetoric. This suggests that heteronormative gendered sexual scripts influence the ways that women conceptualise and negotiate safe sex, even in queer contexts. Importantly, findings reveal that medicalised, heteronormative approaches to safe sex result in reduced health literacy among queer young women, which appears to limit their ability to actively negotiate safe sex with female partners. In this chapter, as in the last, it is participants' queerness that problematises their positioning as "neutral" neoliberal subjects, raising questions as to how they incorporate this into what it means to be a "good" sexual citizen in a post-feminist context.

Considering the important role healthcare plays in participants' descriptions of sexual citizenship in this chapter, in the next chapter I examine the women's experiences of accessing sexual healthcare in Tasmania.

Chapter 6: Sexual Healthcare in Tasmania

Introduction

This chapter builds on Chapter 5 by analysing how Tasmanian bisexual and queer young women experience and negotiate inclusivity in sexual healthcare with general practitioners (GPs). I argue that although the women embody a privileged neoliberal, post-feminist sensibility, their discussions of accessing healthcare in Tasmania complicate their claims to homonormativity and further demonstrate the processes of disidentification. This chapter is structured in three parts. Part 1 contextualises participants' healthcare experiences by outlining Australian LGBTIQ-inclusive health policy and best practice models. Next, I describe participants' lived experiences of healthcare in Tasmania. In the final part, I discuss Tasmanian medical practitioners' approaches to inclusive practice, comparing and contrasting these with the women's accounts.

As described in Chapter 1, Tasmania has a unique socio-economic and health profile. In rural Tasmania for many years it has been difficult to recruit GPs, so access to healthcare is challenging – with less than 66 full time GPs for every 100,000 people in some areas (DHHS 2013c, 2009a). Subsequently, Tasmanians report increased difficulties accessing health services, they visit GPs less, and have poorer overall health literacy than the national average (ABS 2014a). There are also disparities in health and access to health services within Tasmania, with the rural North and Northwest regions facing pronounced socio-economic disadvantage and poor health compared to the more densely populated South (see DHHS 2009c). These disparities are likely to be further exacerbated for LGBTIQ Tasmanians.

The majority (12) of participants live in the capital city of Hobart or its surrounding suburbs in Southern Tasmania, the only metropolitan part of the state (see AIHW 2017). Three participants live in the Northern rural centre of Launceston, with some having grown up in rural towns nearby. In Tasmania, the

state-wide Sexual Health Service operates as part of the State Government Department of Health and Human Services. This service has clinics in Hobart, Launceston, and Devonport and provides clinical services and counselling for gender, sexuality, and sexual health. The Sexual Health Service is LGBTIQ-inclusive and provides education and support to other healthcare providers on LGBTIQ health issues, particularly HIV testing and treatment, transgender health, and hormone replacement therapy. In collaboration with the Sexual Health Service, the Tasmanian Council for AIDS, Hepatitis and Related Diseases (TasCAHRD) also operates a weekly STI and HIV testing drop-in clinic in Hobart, primarily catering to the LGBTIQ community. *Headspace,* a national LGBTIQ-inclusive youth mental health service has clinics in Hobart, Launceston, and Devonport. Tasmania's state-wide LGBTIQ support and education service, *Working It Out*, also operates in Hobart, Launceston, and Burnie, offering free counselling, peer support groups, and information for the wider community. While there are no other dedicated LGBTIQ health centres or services in Tasmania, participants identify a number of general practice clinics that either explicitly or implicitly welcome LGBTIQ patients in Southern Tasmania. However, while the Sexual Health Service and Headspace operate in Launceston, participants are not aware of any other Northern health services that are LGBTIQ-inclusive.

Contextualising Inclusive Health Practice in Australia

The role of western medicine in perpetuating the stigmatisation and "othering" of the LGBTIQ community is well-documented (see Foucault 1979; Fish 2006; Seidman 2002). As discussed in Chapter 1, there is a significant body of social research revealing healthcare providers' discriminatory views and practices towards LGBTIQ patients (see Barbara et al. 2001; Beehler et al. 2001; Hinchliff et al. 2005). In addition, British and Australian research shows that GPs seldom feel comfortable or qualified to address the specific health needs of LGBTIQ patients (Hinchliff et al. 2005; Jones et al. 2002; McNair 2003; Stott 2013). This has arguably influenced lower rates of health-seeking behaviours and self-disclosure among LGBTIQ patients, especially bisexual and queer women (see

Koh et al. 2014; McNair 2009; McNair et al. 2015; Mulligan and Heath 2007; Scherzer 2000). In light of these issues, recent national reports emphasise the need to develop more LGBTIQ-inclusive health service provision in Australia (see AHRC 2015; Robinson et al. 2014). Here, I describe LGBTIQ-inclusive health practice and outline current approaches to inclusive health in Australia to contextualise participant experiences.

With the rise of patient-centred care, greater emphasis is increasingly placed on improving patients' healthcare experiences and empowering them in the process of treatment (see Epstein and Street 2011). This coincides with social changes that have precipitated the decline of medical dominance and the democratisation of medical knowledge and healthcare (Turner and Samson 1995). Neoliberal ideologies shape the contemporary Australian health system, as patients are positioned as empowered, individual consumers who demand quality treatment and value for money (see Ayo 2012). This climate has altered traditional doctor-patient relationships, as patients increasingly relate to GPs more as service providers than experts and authority figures. Therefore, medical advice, decision-making, and care are now more scrutinised and evaluated by lay people than in the past. In this more reflexive, neoliberal culture of health, consumers are hyperaware of what constitutes a positive healthcare experience.

LGBTIQ health advocacy has coincided with these historical shifts in medicine, with the demand for equitable healthcare access, treatment, and research playing a significant role in LGBTIQ rights activism since the earliest homophile movements of the 1950s (see Epstein 1998; Jagose 1996). In 1994, the Council of Scientific Affairs of the American Medical Association updated its policy on gay and lesbian patients, observing that their healthcare is compromised when heterosexuality is assumed in health settings (McNair 2003: 90). Following this, the Institute of Medicine issued a document outlining recommendations for lesbian health (see Solarz 1999), which suggested that more information about lesbian health should be distributed to healthcare providers and the general public. Similar developments occurred in Australia at this time, with the Australian Medical Association (AMA) (2002) issuing a position statement on

sexuality and gender diversity, emphasising the need for improved education for healthcare providers in the area of LGBTIQ health. More recently, the AMA's 2014 position statement on sexual and reproductive health identifies LGBTIQ people as a target group for special consideration, stressing the need for equal access to healthcare that is free from discrimination.

Contemporary LGBTIQ-inclusive health practice is conceptualised as a systemic approach to equity in health (Barrett et al. 2013). According to the Gay and Lesbian Equality Network, inclusive or diverse mainstream health practice has three organisational aims: 1) recognition and respect for the diversity of the client population, 2) understanding the issues facing diverse client groups, 3) providing an accessible and appropriate service and referral (see Barrett et al. 2013). Following these directives, in 2008 Gay and Lesbian Health Victoria (GLHV) established a six-point model of inclusive practice that has become the national standard endorsed by the Royal Australian College of General Practitioners (RACGP) (see GLHV 2013; McNair 2012). The six aspects of inclusive practice encompassed by this standard are: 1) access and intake procedures, 2) consumer consultation, 3) cultural safety, 4) disclosure and documentation, 5) professional development, 6) organisational capacity (see Barrett et al. 2013). GLHV also established the Rainbow Tick accreditation initiative to encourage the application of this inclusive practice model in health and human services in Victoria.

With increasing awareness of LGBTIQ health in Australia over the past three decades, the RACGP 2016 general practice curriculum now includes a comprehensive unit prioritising sensitivity and inclusion of sexuality and gender diversity in Australian general practice settings. The RACGP provide biannual national guidelines for general practice. The purpose of these guidelines is to assist medical schools, general practice supervisors, and specific interest groups to design learning programs, courses, and assessments that meet national standards for medical practice (RACGP 2016). According to the RACGP (2016) "the core skills that form the centrepiece of the Curriculum for Australian General Practice clearly state, in measurable terms, the knowledge and skills

required for each stage of general practice training." The core skills and recommendations for GPs in the 2016 curriculum reflect the GLHV inclusive practice model. For instance, in addition to providing information about LGBTIQ health risks and disparities, the curriculum states that doctors must strive to be respectful and supportive of sexual and gender diversity, take an open-minded and non-judgmental approach, recognise and address heteronormative language, and familiarise themselves with LGBTIQ-sensitive referral networks (RACGP 2016 SG16). The curriculum situates inclusive practice as part of GP advocacy, emphasising the importance of challenging discriminatory views among colleagues through peer-education and leadership (RACGP 2016 SG16). For the RACGP (2016 SH16) "GPs need to be competent and comfortable discussing sex with a wide range of people, including those of different ages, genders, sexual orientations, cultural and linguistic backgrounds, and people with disabilities." The recognition of LGBTIQ-inclusive practice in these guidelines is an important part of mainstreaming LGBTIQ-awareness and inclusivity in Australian healthcare into the future.

In Tasmania, there has been some recognition of the need for policy development with respect to LGBTIQ health, with the establishment of a state government advisory committee in 2000 (McNair 2003: 90). In 2013, a government action plan and background paper on Tasmanian LGBTIQ suicide prevention outlined the need for improved access to services and information for the LGBTIQ community (see DHHS 2013d). This report specifically identifies the need for Tasmanian health services to adopt more inclusive practices and recommended the establishment of the Victorian Rainbow Tick inclusive accreditation program in Tasmania. Although this recommendation has not been adopted, Working It Out has hosted awards recognising inclusive health, education, and human service provision across the state since 2012. A whole-of-government framework for LGBTIQ inclusion was released in 2015 (see DPAC 2015). The plan states that "LGBTIQ Tasmanians should be able to identify and access services that meet their needs without fear of prejudice or discrimination" (DPAC 2015: 2). Improving professional learning opportunities and resources for Tasmanian health and human service providers is also

identified as an important aim of the plan (DPAC 2015: 5).

Given this context, I was interested examine young women's experiences of inclusive practice in Tasmania and what, in their view, constitutes sensitive healthcare.

Queer Women's Experiences of Sexual Healthcare in Tasmania

Apart from two participants who have not accessed sexual healthcare, all participants attended a GP for preventative sexual health screening, such as Pap smears and STI checks. Four participants preferred attending youth health services or Family Planning clinics for their sexual healthcare. In the following sections, I discuss the critical factors contributing to negative and positive experiences of care in Tasmania. Negative experiences include: 1) structural and conceptual inaccessibility of inclusive healthcare, 2) judgmental practitioner attitudes, 3) heteronormativity, and 4) lack of awareness about LGBTIQ issues. Positive healthcare experiences include: 1) non-judgmental practitioners, 2) use of inclusive language, and 3) knowledgeable practitioners and/or those who willing to self-educate.

Structural Accessibility

> I really want to move to Hobart!! (laughs) Because it's just… I can walk around in Hobart with my shirt tucked in and being really loudly gay and it's fine, cause no one really gives a shit… Yeah, like obviously, there's still trouble, but it's sort of more… accepted… There's more creativity in Hobart, more liberal people… It just is… It feels like a safer environment… Whereas here… because I know people here and it's such a small town as well, and we're such gossips because it's a small town, and there are churches everywhere… It just, doesn't… I can't really see any doctors here, because everyone knows you. It's such a small town, it's such a small mind-set… Because there's that… not really rural influence, but maybe small town influence, but because Hobart's like the capital city and, like,

> it's all cultural and there's [the Museum of Old and New Art][1]… and there's all this cool stuff, there's better services, it's sort of quietly OK to be queer in Hobart. That's where all the poor queer kids go… the ones who can't move to Melbourne… (Francesca, 20, pansexual, Northern Tasmania).

Geographic location is a key determinant of health that is further exacerbated for queer young people in regional and rural areas (see Farmer et al. 2015; Johnston et al. 2015). In line with the well-documented barriers to healthcare faced by rural young people (see Bishop 2013; Hillier et al. 1999; Johnston et al. 2015; Senior et al. 2014), Francesca's account encapsulates the difficulties queer young people face in rural Tasmania. Of the 15 participants, seven intend to leave Tasmania and four have previously moved interstate but have returned. Three participants specifically identify the lack of inclusive health services and social support as the reason they intend to leave. Despite cultural improvements in Tasmania's acceptance of the LGBTIQ community over the participants' lifetimes, few perceive these to have extended to inclusive health and human services:

> There just aren't really any services here… I'm actually thinking of moving to Melbourne so that I can access better services… so that I can get a whole lot of ah things that are really difficult to get in Tassie. On the mainland, like, in Melbourne, there are places like Northside, which is, like, an STI specific clinic, but it also does general… queer… health… So it's just a really accepting clinic.. and there's.. There's just nothing here for that. There's a sexual health clinic somewhere, but I don't think it's… Necessarily… it's not, like, an explicitly queer friendly health service. So, you've just got to get lucky with a GP. (Frankie, 25, bisexual, Hobart).

[1] Recent scholarship and social commentary highlights the "regeneration" (or gentrification) of Hobart and Tasmanian culture after the 2011 opening of the Museum of Old and New Art (MONA). This is referred to as the "MONA effect" (see Cica 2013), describing how MONA shaped the regional city of Hobart into an important cultural capital, attracting tourism, urban renewal, and the development of an active arts scene. Francesca uses MONA as an example of how Hobart has become a progressive, queer-friendly city.

> There's only one place to go. You can only go to [Clinic X] and they're getting better but… It's really… But if you go to your doctor, pfft, like, good luck. There are some doctors who are just like "I'm not helping you. Why would I do that?" Or, like, are really weird about it… So, you only really have the one option and if you don't want to go there, then tough shit. Then you'd have to drive to Hobart, or get to Hobart to do all your appointments… (Pip, 20, pansexual, Northern Tasmania)

> Like, um… going on Facebook and seeing someone who's on the mainland and you see that they're like 'I'm going to the Gender Centre and.. they were like totally accommodating of all kinds of queer people' and I'm like… here… our options are [Clinic X] and they're not that great. Um… so… yeah.. it's just sort of just… dealing with the fact that this is a small town… There's… nothing… Like most of the um real specialist stuff is in Hobart… I'll probably need to go to Hobart anyway, but, if you live up here, and you can't get down there, then forget it! It's very much like… I can't do anything here regardless of how I feel. (Harley, 19, asexual, Northern Tasmania.)

References to queer friendly health services on "the mainland" (e.g. Northside, the Gender Center), are common among participants, who feel that more dedicated LGBTIQ services in Tasmania would benefit queer young people. In the extracts above, participants hope to overcome barriers to inclusive healthcare by relocating to Hobart or interstate. This demonstrates the queer rural exodus narrative reflected in popular culture and previous research on rural queerness (see Aleksandrs 2015; Bell and Valentine 1995; Kazyak 2012). Participants in the South often frame the "mainland," particularly Melbourne, as a queer "promised land." For example, Frankie's account reflects statistics that demonstrate Tasmanians' increased difficulties accessing healthcare and the impact this has on mental health (see ABS 2014b). In contrast, participants, like Francesca, in the rural North are more likely to position the capital city of Hobart as queer space, as opposed to their repressive, rural Northern hometowns (see Baird 2006; Bell and Valentine 1995; Binnie and Valentine 1999; Kazyak 2011). I

argue that privilege plays a role in young Tasmanians' abilities to access queer urban spaces, and, hence, improved health services and social supports, as the ability to relocate depends on access to transport and economic capital, which may be less attainable for young people in more isolated rural areas (see Farmer et al. 2015; Le et al. 2012; Johnston et al. 2015).

Farmer et al. (2015: 5) similarly found that a lack of access to inclusive health services further isolates rural bisexual women and contributes to increased rates of mental illness and risk behaviour (see also Cohn and Hastings 2010). While there are a number of Tasmanian sexual and mental health services that are inclusive of the LGBTIQ community, participants do not feel these are sensitive enough to queer young women's needs. Frankie and Pip refer to the process of finding a queer friendly GP as "getting lucky," as there are no formally established or mainstream accreditation processes in Tasmania to indicate that a clinic or practitioner is LGBTIQ-inclusive. Here, the use of the word "lucky" implies that finding a GP who is sensitive and aware of queer women's sexual health needs in Tasmania is rare.

In line with Brown-Saracino's (2014) argument that city ecology produces site-specific queer cultures, I found differences in perceptions of inclusive healthcare in Northern Tasmania, compared with the South. Northern Tasmania experiences some of the most pronounced socio-economic and health disparities both in the state and nationally (DHHS 2013b). As Pip and Harley both indicate, the structural barriers to accessing inclusive healthcare are exacerbated for Northern participants, because if patients cannot find a suitable service, they may have to travel up to four hours south to Hobart. Penchansky and Thomas' (1981) framework for equitable healthcare access emphasises that services must be available, physically accessible, accommodating, affordable, and acceptable. However, as Johnston et al. (2015) and Le et al. (2012) observe, unreliable, expensive or inefficient public transport in rural areas can significantly impair young people's access to appropriate and confidential healthcare.

As the Australian Medical Association (AMA) (2012) outlines, in rural areas where there are fewer specialist health services, GPs take a greater responsibility for treating a wider range of conditions, placing extra strain on their workloads. In this context, Pip and Harley believe that inclusive services are not available to them in Northern Tasmania. Despite the existence of at least two LGBTIQ-inclusive health services in Northern Tasmania, participants do not perceive these to be suitable, accessible, or adequately inclusive of queer young women's needs ("here… our options are [Clinic X] and they're not that great"). Like Francesca, Pip experienced difficulty finding a queer-friendly GP in the state's North. In Pip's experience, her doctors have ranged from outwardly discriminatory ("I'm not helping you.") to subtly prejudiced ("really weird about it"), with few being accepting of her identity and inclusive of her needs (see also Hinchliff et al. 2005; McNair et al. 2015).

Whitehead et al. (2016: 2) suggest that identity can either act as a barrier or a support in accessing healthcare. In this section, participants' queer identities demonstrably limit their abilities to access sensitive healthcare. However, shared LGBTIQ identity can also act as a support mechanism for participants to overcome the barriers they face. As Whitehead et al. (2016: 2) observe, "identification with a community label can add community-specific resources to support one's coping abilities that can decrease the impacts of minority stress." During the period of recruitment and data collection, I observed strong peer support and self-reliance in the Tasmanian queer community, similar to close-knit, rural queer communities elsewhere (see Barrett and Stephens 2012; Brown-Saracino 2014; Gorman-Murray et al. 2008; Kazyak 2011, 2012). These strong community ties are important for participants to build a sense of local belonging and to foster queer visibility in Tasmania given the history of criminalisation, regional parochialism, and conservatism in the state (see Croome 2013). This often contributed to participants' decisions to take part in this study, as many saw their participation as a form of advocacy or activism – a way of "giving back" to their community. This stance is at odds with participants' neoliberal, post-feminist framings of identity discussed in Chapter 3, demonstrating the urban-centrism of homonormativity. Despite expressing

some ambivalence to sexual identity labels, shared identity as queer allows participants to access important avenues for peer-support that help them to overcome structural barriers and build resilience. For example:

> [My friend group is] a really safe environment, and… as a squad, we protect each other and.. we were saying before, like 'second gen squad' and things like that, so we… The baby gays who come in and they don't know anything, people like… M come in and teach them what to do… so that they know.. Cause… obviously we're not taught… these things, so M is like 'make sure you're safe', and 'you can use my house if you need it' and all this crap… So, like, if anyone's having like trouble at home, M will take anyone… like, if anyone gets kicked out or is having trouble with their family, or is homeless, M will take them.. or like any of the others who've moved out, like, we'll take them… (Francesca, 20, pansexual, Northern Tasmania)

> Yeah, I mean 90 per cent of my friends are gay. Being in Tasmania is actually…probably nicer because its such a small community, because everybody knows everybody, so, I mean, even if you're on the outside, you aren't for long. Somebody will sort of pick you up and grab you and be like "oh hey! Come, come meet all of my gay friends!" (laughs) But that's where I've found all my information um.. support.. yeah. The fact that people in the community all sort of band together, sort of supporting each other is always a really good thing. (laughs) (Jayden, 20, pansexual, Southern Tasmania).

The "close knit" nature of Tasmanian life facilitates ties to community (see also Kazyak 2011: 571). Just as participants turned to online communities for peer support and DIY queer sex education in Chapter 4, participants in rural Tasmania respond to the dearth of LGBTIQ-inclusive health services by building resilience within their communities. Although Tasmania lacks corporate LGBTIQ organisations, health services, and social networks like those in major Australian cities, the extracts above show that Tasmanian queer young people have a strong

sense of community and place that shapes their approaches to healthcare access, advocacy, and peer-support.

In the next section, I examine conceptual barriers to healthcare using Muñoz's (1999) "disidentifications" to make sense of participants' shift from ambivalent neoliberal subjects to critical queers in the context of healthcare access in Tasmania.

Conceptual (In)accessibility

In addition to the structural barriers to healthcare in Tasmania, I found that participants experience a number of conceptual barriers to health. Whitehead et al. (2016) apply Herek's (2007) framework for understanding stigma-related experiences to primary healthcare-use among rural LGBTIQ populations. They observe that a combination of "anticipated, internalised, and enacted stigmas" contribute to avoidance of healthcare (Whitehead et al. 2016: 2). Anticipated stigma is a conceptual barrier for participants in this study, as five admit to avoiding preventative sexual health screening due to the perception that Tasmanian practitioners will not be accepting:

> I was talking to one of my friends and she said she had [a pap smear] done and she went through some of the stuff they do for the test.. She said there's like this… weird steel pole thing that scrapes something! And that's really intrusive! That scares me! (laughs) That made me a bit… [hesitant]. And, like, one of my friends uh.. went to.. had to go to the doctor for a check up, and they're like "have you been sexually active in the last few months?" and she's like "yeah!" and they're like "have you used protection" and she's like "No…" And then they're like… Oh.. Um.. She like asks a question like, why not… and she's like "I'm.. a Lesbian" and they were like (uncomfortably) "Oh! Oh! Oh! Ok… Um…" So, I don't think I'd… I think I'd be really scared to go to a GP anyway even if.. If I thought I had some sort of like.. Like infection.. or anything… Nah. I wouldn't want to go! (Middy, 19, fluid, Southern Tasmania)

> I, I, don't even feel comfortable telling most doctors, to be honest. I put off even going for ages… Because they'll treat you differently. Because a lot of people are homophobic. A lot of people are biphobic. A lot of people are transphobic. That tends to be the default. If I told someone I was queer.. you know… I might get different treatment, I might not get my other issues taken as seriously… It's a risk… It's a risk.. It's, it's… Othering yourself… (Max, 21, bisexual, Southern Tasmania)

Anticipated stigma is a concern in the Tasmanian healthcare context, in particular, given the dearth of mainstream LGBTIQ-inclusive services and an assumption among participants that rural health services are heterosexist. As these participants demonstrate, misconceptions about Pap smears, coupled with fear of stigma, dissuade young women from accessing preventative sexual healthcare (see also Formby 2011a). In line with the literature on lesbian and bisexual women's disclosure in health settings (e.g. Austin 2013; Barbara et al. 2001; Formby 2011a; Kitts 2010; Koh et al. 2014), anticipated stigma also deters participants from disclosing their sexuality to doctors. Like Scherzer's (2000) US study, friends' negative past experiences in health settings influence Middy's perception of healthcare practitioners, producing a sense of anticipated stigma. As discussed in Chapter 4, the problem-based nature of the SRE Middy received contributes to her association of sexual health with fear and stigma. For Middy, the social stigma around sexual health, especially for young women, acts as a deterrent from seeking healthcare ("I'd be really scared to go to a GP…"). Inclusive practice models for LGBTIQ young people emphasise the importance of health practitioners encouraging self-disclosure and responding to such disclosures in an encouraging and positive manner (see Barrett et al. 2013; GLHV 2013; RACGP 2016 SG16).

Anticipating a negative or discriminatory reaction from practitioners is the most common reason for queer women delaying or avoiding accessing healthcare and this is further exacerbated in rural areas (see also Austin 2013; Barrett and Stephens 2012; Farmer et al. 2015; Mulligan and Heath 2007). As Warr and

Hillier (2001) demonstrate, the perceived lack of anonymity in rural areas with small populations impacts young people's health-seeking behaviours, especially in regards to gendered or sexual health (see also Bishop 2013; Hillier et al. 1999). Furthermore, rural queer patients are less likely to disclose their sexuality to healthcare providers if they are not "out" in their communities (Barrett and Stephens 2012). Rural spaces are often stereotypically associated with homophobia in popular queer narratives of place (see Binnie and Valentine 1995; Halberstam 2005). Similarly, participants anticipate heterosexist stigma from Tasmanian practitioners as they perceive homophobia/biphobia as the norm in Tasmanian health and human services. This is possibly an effect of participants' fears of the wider social consequences of stigmatisation from doctors in small towns where anonymity is not possible (e.g. outing, discrimination, no other available health services). The Tasmanian socio-historical context of criminalisation, conservatism, and discrimination against the LGBTIQ community may also shape young people's anticipation of stigma in Tasmanian healthcare settings. Thus, queer young women are more likely to accept discontinuous care, or care based on incomplete information, than risk potential discrimination from healthcare providers in rural Tasmania (Mulligan and Heath 2007: 471).

In line with the literature on bisexual health, participants in this study are unlikely to disclose their bisexuality when accessing sexual healthcare due to a perception that bisexuality is "irrelevant" to their health. Because six of the participants are in relationships with men, few see their bisexuality as an aspect of their identity they need to disclose to practitioners:

> It's kind of not really relevant. So… I guess if I had a girlfriend, I'd tell her… When she's doing like the social history background… But otherwise it's not relevant for me to bring it up. (Isabelle, 21, queer, Hobart)

> I wouldn't seek out like a specific.. queer… like sexual health service, or women's health service because I just feel like.. I … I… guess because I'm pretty ambivalent, so it's like I don't really care if you treat me as queer or

> straight, it doesn't matter, so it doesn't matter if I went to a regular GP… I don't.. feel like my sexual identity is.. my identity… It's just something I do, so you might as well treat me for… Like I wouldn't be like 'I've had sex with a woman, can you…?' It would be like 'I've just had sex and I think there's something wrong with me, can you check that out?' like I wouldn't… So, I'm not uncomfortable about going to a general practitioner… Yeah.. I guess… If I felt really strongly about my sexuality or gender identity, I'd probably seek out services that were… really… tailored to me.. but I feel general enough as a human being to go to a general health service (laughs) I am a general person. (Sloane, 26, queer, Hobart)

Positioning bisexuality as irrelevant to healthcare reproduces the very bi-erasure that participants took issue with in Chapter 3. Despite bisexual and queer women experiencing a number of increased health risks and disparities, they are much less likely to access services and disclose their identities than lesbians and heterosexual women (see Mulligan and Heath 2007; Pallotta-Chiarolli and Martin 2009). Although nine participants disagree with mainstream assumptions that sexual identity is defined by sexual behaviour, when discussing sexual health, seven participants believe that it would only be relevant to disclose their bisexuality if they had a female partner. These views suggest internalised stigma because participants unconsciously echo biphobic sentiments that invalidate women's bisexuality by positioning it as not "real" and therefore not relevant to healthcare. This acts as a potential barrier to accessing inclusive healthcare, as young bisexual and queer women's decreased likelihood of self-disclose due to biphobia may diminish their quality and continuity of care (Mulligan and Heath 2007; Pallotta-Chiarolli and Martin 2009).

Here, the neoliberal politics of normalisation, outlined in Chapter 3, influences the ways participants approach sexual healthcare in Tasmania. By positioning herself as a "general person" who does not require a "specific queer sexual health service," Sloane reflects the narrative of emancipation (see Coleman-Fountain 2014). These participants deploy homonormativity by portraying

sexuality merely as a set of behaviours rather than a greater identity relevant to whole-patient care (see Ng 2013; Stein 2010). This shapes the ways women perceive and approach sexual healthcare, because, as someone who is "ambivalent" about sexual identity labels, Sloane prefers to access health as a neutral individual rather than a politicised minority. Seeing oneself as a "general person" can be interpreted as a homonormative means of denying "otherness," or avoiding stigma by not emphasising sexuality as an important aspect of the self. As I discussed in Chapter 3, privilege shapes this approach, as it is middle-class, urban, predominantly white women who hold these views, while those in rural areas, with poorer access to inclusive health services and lived experiences of explicit homophobia, are more likely to stress the need for specialist queer health supports.

Neoliberal ideologies paradoxically influence the proliferation of specific identities (see Chapter 3), while simultaneously limiting these identities in the context of healthcare access. Participants find they have to negotiate their identities in order to engage with social structures that do not recognise or accept their fluid approaches to identity. Despite identifying with a range of specific queer sub-groups, when accessing healthcare all participants articulate their identities in more simplified terms. For example, Jayden identifies as pansexual, but she has told her GP she is "'gay', because it's just easier." Jess identifies as bisexual and is in a long-term monogamous relationship with her female partner, with whom she has a child, and like Jayden, finds it easier to tell her doctor she is a lesbian. Francesca and Miki identify as pansexual or bisexual, but have told doctors they are "straight" because their current sexual partners are men. Here, participants can be seen as engaging in disidentification in order to access rural healthcare without experiencing stigma in contexts they perceive to be non-inclusive (Muñoz 1999).

Given increasing diversification of sexual and gender identifications some Australian sexual health services are moving away from identity-based services (e.g. "women's health"), instead focusing on body parts. For example, the AIDS Council of New South Wales recently launched a program called "At Your Cervix"

promoting cervical screening to "people with a cervix" (see Cancer Institute of New South Wales 2017). Such services promote inclusivity by not making sexual and gender identifications a prerequisite for treatment. Do such shifts mean that dedicated health services are now no longer necessary in post-gay Australia? And how do queer young women understand sexual citizenship in this context? My findings suggest that with proliferating queer identifications specific health services may no longer be necessary, however, sexuality and gender-affirming mainstream services are. Although participants report accessing mainstream health services, this is usually out of necessity in rural areas where healthcare options may be limited. As the women's discussion of LGBTIQ health clinics in Melbourne demonstrates, several would access specific services if they were available to them. Therefore, LGBTIQ-inclusive practices are essential for mainstream services, while specific queer health clinics are a positive additional option for some. Such considerations of the links between sexual identity and health services suggest that queer young women are engaged in important discussions about their civic participation, their access to essential public services, and their rights to self-determination – important aspects of queer sexual citizenship in action (see Illes 2012; Johnson 2017). Thus I argue that, in neoliberal contexts, disidentification – reflexive considerations of identity and its relation to health politics – is a key part of queer sexual citizenship.

Practitioner Attitudes

Reflecting on their experiences of accessing sexual healthcare in Tasmania, participants identify key factors that determine negative or positive healthcare experiences for queer women. As McNair (2003) and others (e.g. Formby 2011a; Fish 2006; Scherzer 2000) argue, negative past experiences when accessing healthcare sensitise queer patients to both explicit and subtle practitioner displays of homophobia and heterosexism. Similarly, participants in this study place great value on personal attributes of service providers (see also Farmer et al. 2015; Johnston et al. 2015; Kitts 2010). Half of the participants describe their past or current GPs as displaying a "judgmental" attitude, particularly regarding

their sexual behaviour as young women. For example:

> I've had friends who've had doctors say stuff like… Like, one of my friends went to the doctor recently and the doctor was like "so, you know that while you're on antibiotics the Pill won't work" and she was like "yes" and he was like "So you're just going to have to keep your legs together." (Stella, 25, bisexual)

> I was in there and they were sticking this gigantic fucking wand up me… covered in cold, cold lubricant in a dark horrible room… with this man who was like… I totally forget what he said, but he was just.. He was talking about… He said something along the lines of.. "this is a bit of a personal question, but…" and then a question about my sexual behaviour.. And I found that really offensive, because, like, you're a doctor, there's no such thing as a personal question. For you to say that it's a personal question is you putting, like, a qualitative judgment on my behaviour. (Evie, 26, pansexual)

As I argued in Chapters 4 and 5, neoliberal, post-feminist responsibilising discourses associate sexual health with stigma and risk-management for young women. This association between (hetero)sex and risk, that permeates participants' SRE and subsequent sexual experiences, also shapes their experiences of accessing sexual healthcare. In Evie and Stella's experiences, medical practitioners perpetuate risk discourses by acting as gatekeepers or moral assessors of young women's sexual behaviour (see also Powell 2007). These accounts illustrate a common complaint among participants that doctors make inappropriate, sexist or gendered judgments about their sexuality and/or behaviour during sexual health consultations. Here, the medical gaze is a mechanism of social control as (usually male) doctors are positioned as observing women's sexual behaviour with a disapproving gaze. The perceived judgment Evie felt from her doctor aligns with neoliberal healthism, as women's health behaviours are positioned as having a moral element. This is also evident in the shaming, gendered undertone of the comment that Stella's friend should

"keep her legs together." These examples demonstrate the impact of neoliberal governmentality on young women's experiences of sexuality and sexual health, as medical advice and treatment can be used as a form of gendered power and social control.

Given the stigma around youth sexual health, participants consistently report valuing non-judgmental practitioner attitudes as being important for fostering positive health outcomes. For example, in contrast to participants who describe receiving personal judgment from doctors, these participants give positive accounts of their GPs:

> I think I got really lucky with my health professional. I've heard of lots of healthcare people who do impart like biased.. you know.. and react with emotional impulses ... and impart their opinion onto people um.. but [my GP] didn't impart any personal belief, she was just very… 'this is what you need to do, read this flyer, do this, what else do you need to know?' and she was just.. She just dove straight in to the graphic description of it all… It was Great! (Audrey, 20, bisexual).

> She's really helpful and I can ask her anything. She is.. really.. um.. she's .. really knowledgeable. When it comes to things like contraception she's been really quick with like solutions, she's not one to sort of fumble around. She's not afraid to ask any kind of um awkward questions, which is actually good, cause… yeah.. She's very non-judgmental. (Carrie, 23, bisexual).

> Everybody knows that's the place to go and everyone's really chill there … Like, all of the people there are really good and open and really talk to you about things. They're like totally non-judgmental and they're fine about things… (Jayden, 20, pansexual).

For these participants, GPs utilise a non-judgmental approach by not responding with personal opinions or beliefs about their sexuality or behaviour. By

describing the practitioners at this service as "chill," "open," "non-judgmental," and "fine about things," Jayden implies that this is not common in heteronormative health systems. This is consistent with international research on queer women's preferred practitioner attributes (see McNair and Hegarty 2010; Mulligan and Heath 2007) and Australian directives for inclusive practice (see Barrett and Stephens 2012). Because of the punitive, problem-based nature of their SRE, young women highly value healthcare providers who approach sexual health in a calm, open-minded manner. Audrey's GP reflects this approach by not reacting to her sexual health inquiry "with emotional impulses," such as shock, embarrassment or anger. Carrie appreciates that her GP is not "afraid" or "awkward" about discussing sexual health. Jayden values practitioners who "really talk to you about things." These examples illustrate the importance of patient-centred care especially for marginalised groups whose voices have been traditionally excluded from health discourse.

Communicating Inclusivity

Participants especially appreciate practitioners who do not deploy compulsory heterosexuality through their practice. As well as receiving judgment about their sexual behaviour in general, participants also feel that practitioners are particularly judgmental about bisexuality and queerness (see also Scherzer 2000). Doctors are seen to perpetuate compulsory heterosexuality through their frequent assumptions that young women are heterosexual by default (see Barbara et al. 2001; Fish 2006; Koh et al. 2014). Participants outline how doctors' expressions of compulsory heterosexuality invalidate their experiences and reduce the quality of care they receive.

> [Doctors] always assume you're straight. Every time. Um. They don't really tend to give a shit about giving you a Pap [smear] if you haven't slept with men. And they don't ask you any questions about STIs or anything like that, usually if you sleep with women. And when I've mentioned it they get uncomfortable… (Max, 21, bisexual)

> I have no idea if I'm meant to get a Pap smear or not. I did ask my doctor but when I said that I haven't had sex with men it was like... sort of the end of the discussion. He just assumed I'm a virgin and that's it. There was nothing about any queer stuff… Like what if…? What about sex with…? There were no gray areas or anything. I still haven't got a clue! (Jess, 25, bisexual)

As I argued in Chapter 5, due to heterosexist stereotypes about lesbian sexuality and desire, coupled with lower rates of STI transmission between women, many believe that queer women are immune to STIs (see Logie 2014; Power et al. 2009; Richardson 2000). In Max's experience, requesting STI tests as a queer woman makes healthcare providers "uncomfortable" (see also Jones et al. 2002). This reflects the heteronormativity of medicine and demonstrates the need for practitioners to be better equipped to treat queer women with competence and sensitivity (see also Burke et al. 2015; Hinchliff et al. 2005).

In light of these experiences, participants highly value practitioners who are empathetic and willing to genuinely listen to queer young women's needs. In response to the heteronormativity of medicine, participants value the use of inclusive or gender-neutral language by doctors as this demonstrates that they are not assuming heterosexuality. Despite medicine emphasising clinical neutrality, the impact of heteronormativity often means that "neutral treatment" assumes heterosexuality as the default (Fish 2006). This is perpetuated in medical settings through the often unconscious use of gendered language in consultations. For example, participants had been asked if they have "a boyfriend," or it was assumed that being "sexually active" implies they are heterosexual. When one participant requests a prescription for her "partner" (who is a woman), a pharmacist asks for "his" name. Subsequently, subtle use of language is important to participants, where neutral language is interpreted as a sign of LGBTIQ-awareness and inclusivity, putting participants at ease.

> [The staff at Clinic S] were really, really good. They sat me down and told me everything they were going to do, and they asked me lots and lots of..

> different questions, but in such and unbiased and nice, kind way, I felt that they were really super comfortable talking about it. "Have you had sex with any boys? Have you had sex with any girls? Both?" They didn't, like, ask me to define anything, they were like "Yep." And I think it was just nice that, like, my personal doctor, she didn't assume that when I was talking about my partner that he was a boy… Like she would always use the term "partner" as well. Like if they had just assumed, correctly, that it was a boy, then I probably maybe might have felt a little bit like … oh… there's another level to my sexuality that I would… probably ... feel a little bit more stand-offish being open about it… But because they opened with being so open… I felt comfortable in mentioning both. Which… Yeah… I probably wouldn't have been so comfortable if they hadn't had that stance… from the start. (Stella, 26, bisexual)

Practitioners' use of language communicates their levels of knowledge, awareness, and support for the LGBTIQ community. The use of non-assuming, neutral language (e.g. "partner") and asking open questions of all patients without prior assumption about their behaviours or orientation indicates to Stella that the service is "comfortable" with diversity. Stella's account also demonstrates how GPs can encourage self-disclosure from bisexual women through direct, open questions about sexuality and behaviour (see also Robinson 2013; Stott 2010).

As noted earlier in this chapter, bisexual young women in relationships with men are highly unlikely to disclose their bisexuality in health settings unless they feel supported and safe (Mulligan and Heath 2007). Here, it is the doctor's language and attitude that supports Stella to self-disclose. This account is significant as it demonstrates the importance of facilitating self-disclosure among bisexual women seeking sexual healthcare. Despite some participants' assumptions that it is irrelevant for bisexual women in relationships with men to disclose their identity to doctors, Stella's experience supports my argument that inclusive practice is especially important in this context, as it validates her experiences and combats bi-erasure (see also Pallotta-Chiarolli and Martin 2009). This

contributes to improved continuity and quality of care, as Stella now feels more comfortable to be open with practitioners about her sexual behaviour and health needs.

Participants believe practitioners' lack of awareness of LGBTIQ-inclusive practice is the main contributor to negative healthcare experiences. GPs' level of knowledge and awareness of LGBTIQ health presents itself to participants through their use of language, with doctors frequently using inappropriate or outdated words to refer to LGBTIQ patients. Frankie identifies these language barriers as a key challenge for inclusive practice:

> Well yeah… there's community language and there's… institutional language and… Um… gosh darn it, they try their best but they're just not getting it. You know… and it's hard, you know, unless you know queers, you're not going to know queer language, like it's a very specific set… of… words… and they change a lot and you have to have a certain kind of… privilege in that… being able to keep up with language... and you have to have time and not be a… carer. You have to not be doing all of these things that the people who have the right language are people who are privileged. So you've got to think about it like that... but it's also… like… I don't think there's any doctor who wouldn't say they were, like, privileged so … I kind of think… they have no excuse, like, to not keep up… but I also know there are reasons why… like people aren't involved in the community so they don't... know…

Frankie's account demonstrates the differing levels of social and cultural capital involved in being inclusive. While many other participants are angry with doctors failing to meet their needs or using incorrect, out-dated or offensive language, Frankie recognises that "community language" and "institutional language" are products of a certain kind of cultural capital. In this view, it is understandable that medical professionals may not be aware of LGBTIQ-inclusive language and practices, as they have not been incorporated into their professional culture. However, as Frankie mentions, doctors have long been

positioned as professional and social elites with considerable access to expert knowledge and authority. According to the AMA (2011: 3) doctors undergo a "highly complex and rigorous process of education and training [that] is certified through highly-demanding examinations and in-course assessment processes supported by formal registration." The RACGP (2016, CS16) similarly emphasise general practice as a process of lifelong learning. In a climate where the dominance of medical authority is increasingly challenged by the proliferation of information online, lay-understandings of health, and alternative medicine, the AMA's stance arguably reasserts the status of doctors by emphasising the rigorous process of building medical expertise.

Participants stress the need for greater knowledge and awareness through improved education and training opportunities for Tasmanian GPs and other health service providers:

> Education. That's the only thing that's ever going to make a difference. Awareness. There's a lot more awareness and services for… like… strictly binary gay-straight people… but not necessarily bi or trans… Everything else just needs that little bit more… more education… (Harley, 19, asexual).

> It's like, here… they're just not intersectional in how they approach sexuality and gender. Like, there are no gray areas. I'm always assumed to be straight... If I mention my girlfriend.. they're always assumed to be cis[gender], um.. but they're not… And.. But it's just about training, like people having information about how to talk about it or having that kind of thing... in the back of their mind when they're talking with people and that's… a big gap I think. Yeah, the training's not really there… (Frankie, 26, bisexual)

> There's not much… Not much education for… the health services… We need more information… UTAS definitely needs to do more trans, non-binary, and queer inclusivity in medicine… for the medical students.

> Because… I definitely know that the first year med students... don't get heaps. They're trying, but they're not trying enough. (Isabelle, 21, queer).

These participants suggest there is a knowledge gap around inclusive practice among Tasmanian GPs that needs to be addressed through further awareness training. This demand is supported by the AMA's (2011) stance on the role of doctors, which emphasises the importance of life-long education and training, and community involvement. Frankie and Isabelle, who have both lived interstate, identify Tasmania's geographical isolation as shaping local practitioners' lack of awareness. With a small, relatively homogenous, largely rural population, Tasmania's lack of large, corporate LGBTIQ-organisations and gay scene reduces queer visibility and mainstream awareness. Furthermore, given the range of pronounced socio-economic and health disparities in Tasmania, health funding, policy, and practice is often stretched across many rural/regional health issues. To gain a more detailed sense of the needs and experiences of healthcare providers in Tasmania, in the next section, I examine Tasmanian general practitioners' approaches to inclusive practice and the challenges they face in regional and rural contexts.

Professional Approaches to Inclusive Practice in Tasmania

Following a grounded theory approach (discussed in Chapter 2), after conducting several interviews with women, I identified medical practitioner knowledge and attitudes as a common theme warranting further exploration. Subsequently, I conducted additional interviews with doctors to supplement the women's accounts. This section examines how six Tasmanian GPs negotiate inclusivity with LGBTIQ patients. Five of these GPs practice in the greater Hobart area in Southern Tasmania and all report some awareness of LGBTIQ-inclusive practice. I wanted to hear from Tasmanian healthcare practitioners about their understandings of inclusive practice and their approaches to providing culturally competent sexual healthcare to queer young women in Tasmania. I will evaluate the extent to which practitioners' approaches reflect the RACGP 2016 Curriculum and GLHV inclusive practice guidelines discussed earlier. Do GPs'

professional practices correlate with these best practice models? How do GPs operationalise inclusivity in health and how is this negotiated with queer patients? This data is exploratory and intended to provide a "snapshot" of professional approaches to inclusive practice in Tasmania.

Being Visually Inclusive

As Barrett and Stephens (2012: 7) outline, at the first point of contact with a health service LGBTIQ patients will search for indicators that it is an accepting and inclusive space for them. Given the long-spanning medical mistreatment of LGBTIQ people, queer women are especially distrusting of health services, making them unlikely to present unless they feel safe (see Barbara et al. 2001; Fish and Wilkinson 2003; McNair et al. 2015; Mulligan and Heath 2007). To extend a message of welcome and reassurance to the LGBTIQ community, both the GLHV inclusive practice model (2013) and the RACGP curriculum (2016) emphasise the importance of visual indicators of inclusivity. While there is no inclusive practice accreditation process specifically for health services in Tasmania, the Tourism Industry Council of Tasmania and Rainbow Communities Tasmania have established the Rainbow Tasmania Tourism Accreditation. Under this scheme, Tasmanian businesses that meet a code of ethical guidelines and demonstrate awareness and commitment to equal treatment of LGBTIQ patrons and employees can seek accreditation and display a rainbow Tasmania symbol. The Rainbow Tasmania Tourism Accreditation states that displaying a visual symbol of inclusivity produces "greater LGBTIQ client satisfaction" because it identifies an "LGBTIQ-friendly" service for patrons who may be unsure (Tourism Industry Council of Tasmania 2017). Two of the clinics I visited explicitly advertised their "gay friendly" status with rainbow Tasmania stickers (see Fig 6.1).

Fig 6.1 – Rainbow Tasmania Tourism Accreditation logo, displayed in windows of inclusive Tasmanian businesses (Source: https://tict.com.au/tourism-accreditation/rainbow-tasmania-tourism-accreditation/ Accessed: 13 April 17).

Displaying visual signs of inclusivity is often practitioners' first response when asked about their approach to inclusive practice:

> I think you do need some kind of… physical signs in the surgery… Just, yeah, including some brochures around the surgery, there's some posters... a poster near the front door as you walk in telling you about… that the practice doesn't discriminate against anyone because of their sexuality… Because not all practices are… kind of inclusive… So, I think if there's a sign, people will just connect with that, even if it's just a little rainbow flag sticker, or a rainbow flag on the desk or something… Yeah, they just feel… they go "yeah, ok." (Dr. R, General Practitioner, 40s).

> Having just a few discrete signs in the waiting room.. to show patients that we welcome diversity.. is very important to.. to those patients. Um. I think we could probably do a bit better there, but… You know, we've got some rainbow posters and, I think.. most importantly um.. we have sexual health information that's relevant to a range of um.. to LGBTI people… That just sends a very clear message of acknowledgement. (Dr O, Sexual Health Specialist, 50s).

These practitioners recognise how patients engage with symbols that communicate inclusivity, emphasising their importance given that LGBTIQ people have been systemically marginalised by health systems ("not all practices are… kind of inclusive"). Similarly, displaying information brochures targeting LGBTIQ patients provides a visual indicator that the clinic understands and accommodates the needs of that population, in addition to normalising sexuality and gender diversity (see RACGP 2016 SG16). As the women similarly noted, this is especially important in the Tasmanian context, where there are fewer visible and active local LGBTIQ communities and established services (see also Barrett and Stephens 2012; Lea et al. 2015). For practitioners, displaying visual signs of inclusivity in clinic waiting rooms helps to put LGBTIQ patients at ease and fosters self-disclosure ("yeah, they just feel… they go 'yeah, Ok.'")

All practitioners identify the importance of health promotion materials (e.g. posters, brochures) that display diversity. The RACGP (2016) support this approach, stating that GPs should strive to create an inclusive practice environment that serves to represent and normalise diverse sexual orientations (see also McNair 2012). Similarly, one of Mulligan and Heath's (2007: 470) key recommendations for GPs is to "make the waiting room welcoming with posters and information directed to bisexual and lesbian women." However, no practitioners can identify any health promotion materials in their clinics that specifically target queer women, with the only examples being materials for gay and bisexual men. Health promotion shapes practitioners' awareness and understandings of queer young women's sexual health needs, as three only refer to assisting older, monogamous lesbian couples with IVF as their primary understanding of sexual health needs for queer women. A common complaint expressed by the young women is that Tasmanian inclusive practice often only extends as far as being "gay (men) friendly." This can be seen as a product of homonormativity in health systems, whereby the ideal queer sexual health consumer is a white, urban, HIV-negative, monogamous, cisgender, gay man (see Duggan 2002). Homonormativity in healthcare impacts queer women by reinforcing androcentric approaches to health, perpetuating the erasure of queer women's sexualities and invalidating their sexual health concerns (see Logie

2014). In light of this, although being visually inclusive is an important and effective way of welcoming LGBTIQ patients, approaches to inclusive practice must go beyond these surface indicators of being "gay friendly."

Using Inclusive Language

The women emphasise the importance of inclusive practice in Tasmania given the state's unique health profile and reduced queer visibility. As outlined in the previous section, young people, especially those from rural areas in the North, are hesitant to disclose their sexuality to doctors for fear of stigma and reduced quality of care (see Austin 2013; McNair et al. 2015; Mulligan and Heath 2007; Koh et al. 2014). This is arguably due to Tasmania's small population, conservatism, and the living memory of institutionalised discrimination during the 1980s-90s decriminalisation debate. In line with participant extracts, one of the most common aspects of inclusive practice identified by practitioners is using inclusive language in consultation with queer patients. The RACGP 2016 Curriculum (SG16) emphasises ensuring cultural safety in patient consultations through "realising a need for open-mindedness and avoidance of assumptions, in particular, avoiding heteronormative language and including options for the spectrum of gender and sexual diversity when meeting new patients."

Practitioner approaches to inclusive practice stem from a commitment to treating young queer patients in a "non-judgmental" manner, and to reflect this through their use of language. While "being non-judgmental" is frequently mentioned by both the women and practitioners, in general practice literature (see Hayes 2015; Mulligan and Heath 2007; Williams 2012), and best practice models (see GLHV 2013; RACGP 2016, CS16), it is less apparent how GPs practically display and communicate a non-judgmental approach in interactions with patients. The GP participants provide some examples:

> Maybe in the response to the questions, you just don't… (laughs) you know, if you say 'how many sexual partners have you had in the last twelve months?' and they say, you know, like 'ten' and it's not like

> "TEN!?!" You know, just be like 'ten'… yeah, whatever… just like.. don't overreact to the answers… um.. I guess it's.. it's your response to their answers… uh… not… yeah, not saying anything judgmental about what their response might be, like not saying things like 'oh, that's a lot of partners.' Just like, you know, just being quite casual about it um.. Yeah. Being non-judgmental. Yeah. I just think you have to put away all your biases and discriminations and just… yeah. They've come to you for help and... yeah I just think I try to… yeah, I don't know... make them feel comfortable, yeah, and not... just not.. I don't care what answers they give me, I just feel whatever. It's just… that's what it is and um yeah I don't know… (nervous laugh) (Dr R, General Practitioner, 40s).

> I think good communication is really important. Um… being someone that they can kind of feel comfortable enough to talk about these problems to… I try to provide a non-threatening… non-judgmental approach…So just sort of normalising… making people feel more comfortable about the questions by saying like, "I ask all new patients these questions, please don't feel there's any judgment." Yeah, we need to just say, straight up, oh, you know "can I ask, do you have a partner?" dah dah dah and "do you have sex with men? Women? Or both?" Just get it all out early, and if we offer the answers, it's easy for someone… But I think we just need to… leave our judgment… under the desk… and completely… ask all young people the same questions. And make sure the questions can be asked of anybody. I think that's the key. (Dr E, Sexual Health Specialist, 40s).

Practitioners' frequent use of the term "non-judgmental" echoes its common emphasis in general practice policies and literature (e.g. Hayes 2015; Mulligan and Heath 2007; RACGP 2016; Wang 2014; Williams 2012). For example, the RACGP 2016 Curriculum (SG16) states that GPs must "provide non-judgmental, holistic care that is affirming and positive when disclosure [of sexual orientation] occurs." According to Williams (2012: 745), "effective GPs listen closely and non-judgmentally to their patients, thus creating a safe clinical space for patients to discuss any important aspects of their health." This approach also reflects the

AMA's (2011) stance on the role of the doctor, implores professional conduct in establishing and maintaining trust with patients. In line with McNair's (2009) recommendations for inclusive practice, practitioners emphasise the role of "normalising" in conveying a non-judgmental approach. Practitioners communicate this primarily through observing clinical neutrality but also by building rapport with patients by being friendly and open-minded. Dr R highlights the importance of sensitive tone when communicating with patients ("it's not like 'TEN?!' You know, just be like 'ten'"). Here, being non-judgmental involves focusing on their role in supporting patients to make informed decisions about their health and care options, rather than passing judgment on patients' lifestyles ("They've come to you for help and yeah, I think I just try to make them feel comfortable"). These findings suggest that employing an open, empathetic, and non-judgmental approach in doctor-patient consultation is critical for dismantling barriers preventing queer young women from accessing sexual healthcare.

In keeping with the RACGP 2016 Curriculum, the GPs also mention using inclusive, gender-neutral language to avoid reinforcing heteronormativity (e.g. "partner" rather than "boyfriend"). One way practitioners do this is by taking cues from their patients as to what kind of words to use when referring to gender and sexuality, as the following practitioner explains:

> My biggest fear was saying the wrong thing… Because I know there are a lot of PC terms and… you know… And so now I try to totally avoid labels, or only use ones that are politically correct and are neutral... like "same-sex couple" or "gay" depending on what they sort of feel more… Because it doesn't matter what the words are, it's what it means to the people… So, sometimes they'll say: "I'm Gay. I don't need pap smears," so then I'll say: "Oh, ok, well, gay people do…" So, I think… depending on who the patient is and how well you know them – I just ask. Rather than faffing around worrying about saying the wrong thing. (Dr C, General Practitioner, 40s).

Reflecting the emphasis on being open-minded and avoiding making assumptions in general practice literature (see McNair 2012; RACGP 2016, SG16), all GP participants describe a similar approach to "mirroring" patients' language (see also Mulligan and Heath 2007: 470). This approach is indicative of inclusive practice as it demonstrates an openness and recognition of the language used by queer patients to refer to their own identities, thereby encouraging self-disclosure in healthcare settings (see also Mulligan and Heath 2007). Given the neoliberal health context, some young women prefer being treated as individuals, rather than members of a politicised collective with a generic label (see McNair et al. 2012; Koh et al. 2014). Dr C recognises this approach and adopts a similar neoliberal stance by opting to forgo politicised "PC [politically correct] terms," and focusing on individuals' understandings. This account reflects homonormativity, as when specific terms are used they are assimilationist and depoliticised ("same-sex couple," "gay" rather than "queer.") This practitioner's approach to avoiding labels in favour of asking and adopting those preferred by patients is a fitting response given the discussion of identity and labels in Chapter 3.

As Dr C's account demonstrates, while using sensitive language is one of the most important ways to provide inclusive care, this is also an area that poses difficulties for practitioners ("My biggest fear was saying the wrong thing") (see also Hinchliff et al. 2005; McNair et al. 2012). The RACGP 2016 Curriculum (SG16, SH16) states that "appropriate and sensitive enquiry about sexual orientation" and "taking a non-judgmental sexual history" are core GP skills. However, practitioners lament the challenge of adjusting to using "the right" language in consultation with LGBTIQ patients, and some view this as "extra effort" in the already overburdened Tasmanian health system. McNair et al. (2015) similarly found that fear of "saying the wrong thing" is a common reason GPs avoid asking patients about their sexual orientation altogether. In several interviews, I observed instances of GP participants struggling with inclusive language. For example:

> There's nothing on the wall to say we welcome… um.. LG… What is it? What's the acronym? [Ruby: you can just say LGBT, if you like…] Yep. That. 'We welcome LGB…' all that… whatever the acronym is… (nervous laugh) (Dr F, General Practitioner, 40s)

> It's important to be aware of some of these things, particularly because there is higher suicidal ideation in LG…T… B…um I…. um people… (Dr E, Sexual Health Specialist, 40s).

Difficulty finding the right words to describe sexuality and gender diverse patients is common among practitioners, demonstrating the problematic nature of the "alphabet soup" of queer identity politics for laypeople (see Ghaziani 2011). However, the practitioners' difficulty or, in some cases, resistance to inclusive language also reveals their role in perpetuating neoliberal homonormativity, as they tend to emphasise their focus on patients as "individuals," rather than as "LGB… whatever."

Education, Training, and Leadership

Corresponding with the women's accounts, the practitioners stress the need for improved awareness and education to support LGBTIQ-inclusive medical practice in Tasmania. None of the GPs in this study feel that their formal medical training has adequately prepared them for discussing sexual health with LGBTIQ patients:

> Medical school? No. Nup. Not at all. So this was 25 years ago… So I think a lot's changed. We were very much theory-based and didn't really get to see patients until towards the end… yeah I was soooo not prepared. I've had to teach myself… I just feel really sorry for my early patients … (Dr C, General Practitioner, 40s).

> Nup. No way. No! (laughs) I mean when I think about when I went through uni… there was nothing about that... I mean, I've gone to courses

> myself, taught myself, because you didn't get… I don't know what it's like now, I guess it's a lot different, but back then, no way. (Dr R, General Practitioner, 40s).

In practitioners' experiences, communication skills necessary for providing inclusive sexual healthcare are only learned through experience and self-education. Older practitioners who mention that, while their own medical training inadequately prepared them for inclusive practice, they believe "things are different now," implying that younger doctors are more adaptable to embracing inclusive practices. However, recent research suggests that this may not be the case, with both Jones et al. (2002) and Obedin-Maliver et al. (2011) finding that Australian and North American undergraduate medical students receive little training in LGBTIQ health and continue to display bias against this patient group. In contrast, the RACGP 2016 curriculum and the current medical curriculum at the University of Tasmania, both offer practical experiences, communication skills training, more comprehensive coverage of sexual and reproductive health, and some inclusion of LGBTIQ issues. Although the current curriculum for medical training in Tasmania is more inclusive of sexual and gender diversity since the practitioners' time in medical school, the young women suggest that further improvements could be made.

According to the AMA (2011: 3), life-long education and training is a fundamental aspect of doctors' professional endeavours, with particular focus on the obligation for on-going self-education. In light of this, all practitioners are willing to learn more about inclusive practice. Indeed, a common reason for participating in this research was a desire to learn how to be more inclusive. In the absence of adequate formal education that encouraged inclusive practice, three practitioners sought extra vocational training to familiarise themselves with LGBTIQ health issues. Although all the GPs believe in-service training packages are important for building the knowledge and skills to provide LGBTIQ-inclusive healthcare, Dr N identifies the dearth of resources in Tasmania as a barrier to accessing this information:

> It's, it's something that needs to be more addressed in medical school… it's something that could be enhanced in the GP training… There needs to be more information given, you know, whether it's a journal article or a webinar or… um… conferences on it… it would be nice to have that opportunity for GPs to… get that access and information more readily, especially here in Tasmania where there's less awareness, we're a bit isolated in many ways…

Professional isolation is a major challenge for general practice in rural settings (RACGP 2016, RH16). The practitioners and the women believe that Tasmania's geographical isolation produces challenges in terms of availability and access to training packages and vocational education opportunities. According to the AMA (2012: 2) "poor access to sub-specialist services in rural areas has meant that generalist primary care medical practitioners are increasingly relied upon to provide a significant amount of surgical, anaesthetic and obstetric care in these communities despite a shrinking workforce." In this context, the GP participants often find it difficult to prioritise LGBTIQ-inclusive practice and professional development in addition to their many other clinical obligations. Doctors often only seek information about inclusive practice due to patient demand, with the more openly LGBTIQ-identifying patients a GP has, the more likely they are to specialise in their concerns. All the practitioners recognise that if GPs believe they have no LGBTIQ patients (which is common given lower levels of self-disclosure in rural settings), they will not educate themselves on inclusive practice. Dr E explains the challenges Tasmanian GPs face:

> Yeah. I think that's the big struggle with general practice, just dealing with everything. It's actually very difficult to um keep up and catch up… Yeah, it's really hard for GPs, because if you see one um, say, trans person… um... you're expected to… have the right language and do all that sort of thing, but when you're seeing people with… you know… you're transitioning people who are diabetic onto insulin, and Parkinson's Disease and, you know, someone with a really complicated knee injury… How can you be expected to be.. good at it all? I mean, it's easy for me,

> because [sexual healthcare] is all I do, so it's easy to do extra reading… But if I was a um.. a normal GP.. um you just… I think it's really difficult for GPs, really, really hard. And I feel really strongly about that because I couldn't cope with it all… with raising kids… Um… it was too much… and I think like… a personality thing… I think… I wanted to feel confident in what I'm doing… you know.. cause... things can go wrong if you're not up to date with everything. So where do you [get the time]? Trying to keep up to date with all the… life threatening things… um… the… other… some things just get… it's… it's not a priority… and if you're completely dedicated and you can churn through material and take things on board, that's great. And they're the… wonderful doctors in the community… um… I'm not one of them. (laughs) So that's… why I had to hone in… but… I think for a… a… you know, female GP with kids, working part time, to be expected to be good at it all and use the inclusive language and… it's hard! That's not an excuse! If they're not doing it… um… but I think it's… a big call… to be all over all GP stuff…

Overwhelmed by the complex range of conditions she treats on a daily basis, this practitioner points to the need for increased specialisation (see AMA 2012). Although the young women participants largely believe that doctors have no excuse for their poor awareness of LGBTIQ health, this practitioner's perspective highlights the difficulties many GPs (particularly women) face when attempting inclusive practice in overburdened health systems. Wedderburn et al. (2013) similarly argues that despite the "feminisation" of the GP workforce, younger women GPs with children are less likely to engage in vocational training and leadership opportunities due to difficulties managing childcare (see also Swanston et al. 1998).

Practitioners are similarly less likely to adopt inclusive practice in light of these difficulties, viewing it as another "niche" issue requiring extra work. This practitioner problematically situates LGBTIQ health separately to "the life threatening things" (e.g. Diabetes, Parkinson's Disease), or, higher priority health problems, which disregards the tangibly life threatening nature of the structural

discriminations against LGBTIQ young people in rural Australia (see AHRC 2015; Corboz et al. 2008; Hillier et al. 2010; Robinson et al. 2014; Rosenstreich et al. 2011). However, this account is important because it shows another side to the story presented by the women, illustrating the challenges healthcare practitioners face in the Tasmanian context and explaining why some GPs may be resistant to inclusive practice.

As Barrett and Stephens (2012: 11) outline, the rural context poses specific challenges to whole-clinic approaches to inclusive practice, as these clinics are often likely to have a single "change champion" who is seen as solely responsible for all LGBTIQ-inclusive strategies and initiatives at a practice. This is common in Tasmania, where there are less external supports, resources, and organisations to encourage mainstream, institutionalised approaches to LGBTIQ-inclusive practice. In many cases, the GP participants are the "change champions" of their workplaces.

> I've been trying to… um.. kind of make it more of an inclusive practice… since I arrived here two years ago… it's been a really conservative practice in the past and.. a lot of the other doctors here are… yeah… very conservative… I think.. when it comes to sexuality things. So I guess.. I initially went to places like Working It Out, just to introduce myself, so they would get an idea of.. you know, a GP who they could refer to.. and then in the actual practice… Um.. I think I initially started by… (self-conscious laugh) I put some stickers on the windows… Because when I got here it wasn't... patients… I don't think they felt quite comfortable approaching their sexuality. So now, I'm kind of like their go-to… person. (Dr R, general practitioner, 40s).

In the climate of specialisation, attempts to promote whole-clinic approaches to inclusive practice in regional and rural areas often result in greater effort on part of the "change champion," who becomes known in the clinic as the "go-to" GP "specialising" in LGBTIQ health, even if this is not the case (see Barrett and Stephens 2012). As the clinic "change champion," it is notable that Dr R has

personally ensured inclusivity by contacting external organisations and initiating the display of visual signs of inclusivity, in addition to his high workload as a GP. However, the "change champion" model is not sustainable because it hinges on the efforts of a single practitioner, rather than being institutionalised through practice policy and procedures. Therefore, these findings suggest that a more systematic approach to medical education and training is required to mainstream LGBTIQ-inclusive practice across the broader Tasmanian health sector, ensuring greater support for queer patients.

Discussion

This chapter explores the (in)accessibility of Tasmanian health services as experienced by participants, arguing that place has a profound effect on bisexual and queer young women's access and experiences of sexual healthcare in Tasmania. I also argue that place shapes healthcare practitioners' approaches to LGBTIQ-inclusive practice, with Tasmanian GPs identifying a number of challenges specific to healthcare provision in rural settings. Describing their healthcare experiences, participants report positive sexual health outcomes when their doctors are knowledgeable, non-judgmental, and inclusive, as opposed to heterosexist, judgmental, and lacking in awareness. Findings reveal more practitioner training opportunities are required to raise awareness and improve inclusive healthcare for queer young women in Tasmania. Health services and practitioners can better support queer women and the broader LGBTIQ community by employing a non-judgmental approach to diverse sexualities through communication in consultation processes. In particular, providers already focused on LGBTIQ-inclusive practice would benefit from an understanding of intersectionality and how combined oppressions (e.g. geographic isolation, heterosexism, biphobia) shape rural bisexual and queer young women's sexual health understandings, experiences, and needs.

Echoing the women, the practitioners identify that displaying visual indicators of inclusivity, taking a non-judgmental approach, and using inclusive language are core aspects of inclusive practice. However, practitioners also report several

challenges to providing inclusive healthcare in Tasmania, including professional isolation, high GP workloads, and insufficient training opportunities and resources. I argue that these practitioners' accounts further illustrate the need, also identified by the women, for improved institutional support for LGBTIQ-inclusivity in Tasmanian education and healthcare settings. In neoliberal systems where health consumers seek individualised healthcare and practitioners take a compartmentalised, mechanical view of patient health, it can be difficult to prioritise inclusive practice based on collective identities. Therefore, the women and practitioners both indicate a need for greater LGBTIQ-awareness training to address the difficulties GPs have using inclusive language.

As I observed in Chapter 4, although recent Australian, North American, and British queer geographical scholarship reveals homonormative or post-gay sentiments in young people's relationship with LGBTIQ community spaces (see Brown-Saracino 2011; Lea, de Witt and Reynolds 2015; Pritchard et al. 2002), this is not the case for participants in this study. Participants' accounts of providing material and emotional supports, including sexual health advice to a younger generation of LGBTIQ friends, problematises the neoliberal individualism exhibited in Chapter 3. Here, participants' difficulties accessing inclusive healthcare in Tasmania reaffirms their "outsider" status in heteronormative systems, despite positioning themselves as ordinary, neutral citizens. Therefore, like Coleman-Fountain's (2014) British participants, my participants' claims to "ordinariness" in Chapter 3 are attempts to redraw the lines of normality that are only successful until a point.

In line with existing work on rural LGBTIQ communities, participants face both structural and conceptual barriers to inclusive care in rural Tasmania. I argue that this is due, in part, to the reduced queer visibility in Tasmania, which problematises participants' homonormativity. In contrast to the post-gay discourse invoked by participants in Chapter 3, participants' lived experiences of reduced access to healthcare in an isolated, rural environment see them building communities based on collective identities to mobilise for rights and recognition. This is demonstrative of Muñoz's (1999) disidentifications, as participants

reflexively claim "ordinariness" as a homonormative survival mechanism in order to access healthcare in Tasmania. By emphasising their ordinariness through the "irrelevance" of bisexuality to healthcare, these women downplay queerness in order to avoid being "othered." Therefore, disidentification is a "survival strategy" for some participants to navigate homonormative health systems that invalidate plurisexual or queer experiences (see Muñoz 1999: 11).

However, as Riggs (2010) observes, middle-class white queers regularly focus on their sexuality as a site of primary disadvantage without acknowledging how they benefit from their whiteness and class privilege. This was the case with participants in this study, who were often able to overcome structural barriers to healthcare and navigate these systems because of their cultural and economic capital as white, middle-class women. For example, the ability to move interstate to access more affirmative healthcare and LGBTIQ communities is a product of a particular class position and reflects a white western understanding of individual, mobile identities with fewer ties to community, family, and place. This also reflects participants' post-feminist subjectivities and demonstrates how white queer women can simultaneously occupy positions of privilege and oppression in contemporary neoliberal systems. Here, disidentification helps make sense of these disjunctures between participants' representations of themselves as "ordinary" neoliberal sexual citizens and health consumers in Chapters 3 and 5, and their lived experiences of heterosexism in education (see Chapter 4), sexual health discourse (see Chapter 5), and healthcare access.

Chapter 7: Conclusion

Final Reflections

Sexual citizenship is a complex, contested concept (see Payne and Davies 2012) that is increasingly relevant in the contemporary western socio-political climate. In this thesis I have conceptualised sexual citizenship as a series of rights, obligations, and subject positions that centre on gender, sex, sexuality and intimate life (see Evans 1993; Duggan 2003; Plummer 2003; Richardson 2015). How do we make the "right" sexual decisions? How should I describe my sexual identity and what will this communicate to others? What will this mean for how I access healthcare? The aim of this thesis has been to explore how bisexual and queer young women make sense of "good" sexual citizenship in a particular time and place. My original concern was that the neoliberal ideologies implicit in post-feminism and homonormativity completely divorce queer young women from feminist and queer health politics. However, I have been surprised to find that this was not entirely the case. Instead, I found that queer young women engage in complex, reflexive identity work in order to navigate hetero-patriarchal, neoliberal systems. Analysing my data using Muñoz's intersectional queer theory has enabled me to render visible the ways in which queer young women's politics and disidentifications are mediated through intersecting experiences of privilege and marginalisation. This work is important because it suggests a new narrative of sexual selfhood that positions queer young women as simultaneously incorporating and challenging post-feminism and homonormativity. This affords agency to individuals while also demonstrating how social structures influence the most intimate aspects of our lives, which are at once often the most public and political. Who is the "new" queer sexual citizen? A subject involved in reflexive gender and sexual politics at both a personal and public or political level, a sexual actor who at once questions their identity politics while also advocating for minority rights and recognitions, a critical healthcare consumer, knowledge producer and disruptor. In line with Weeks (1998: 35), this queer sexual citizen is a "hybrid being of our most

intimate life and our involvement in the wider society where the moment of citizenship coincides with the claim to rights of citizens."

For me, the research experience involved a dynamic process of "finding one's voice" through the writing of research (Reinharz 1992: 16). Placing emphasis on self-reflection at multiple stages throughout this project, I considered deeply who I was, what it meant for me to be conducting this research and the nature of my relationship with my participants. At the core of this thesis is a commitment to reflexivity and critical queerness and it is my intention that this research challenges how we articulate identity, how we negotiate sex, and where we position ourselves and others in narratives of health.

To conclude this thesis, I reflect on these key questions and critically evaluate my contributions to intersectional feminist and queer theory, theories of neoliberalism, and health sociology. In addition to these theoretical interventions, I discuss how this thesis addresses knowledge gaps in empirical sociological research on Australian queer women's health and identity. Finally, I reflect on the research process and provide some recommendations for policy and future research.

Overview

Throughout this thesis I have argued that neoliberal post-feminism shapes queer young women's understandings of gender, sexuality and sexual health. In doing so, this research makes new connections between Duggan's (2002; 2012) "homonormativity" and post-feminist theory. I found that the prevalence of conservative, neoliberal politics and ideology in Australia influences homonormative approaches to queerness among white, middle class, young women. This intersects with a post-feminist gender politics where young women are socialised to perceive points of difference as "irrelevant." For bisexual and queer women this results in an individualist "post-identity politics identity politics" (Riggs 2010) in which sexuality and gender are both de-emphasised in favour of "neutral" individuality.

For example, in Chapter 3, I explore how participants understand and employ sexual identity labels. I observe that even though participants are critical of identity politics, many women still choose to articulate their identities with customised labels (e.g. "pansexual," "panromantic," "fluid"). Here, although participants' invoke queerness, I argue that their framings of identity are less illustrative of post-structural "critical revisions" of identity (see Hegna 2007) and moreso exemplify the post-modern neoliberal self as project (see Giddens 1991). In light of neoliberal normalising projects to reduce difference, I suggest that it is unsurprising that white queer young women are increasingly aiming to "redraw the lines of normality" to position themselves as "unremarkable" or "ordinary," with sexuality becoming a less definitive aspect of their identities (Coleman-Fountain 2014: 803; see also Lea 2011; Ng 2013; Reynolds 2009; Savin-Williams 2005). For these young women, identity politics are "unnecessary" or even stigmatising in a neoliberal cultural and political climate that tells (certain) women they are equal citizens – "just like everyone else."

In Chapters 4-6 I focus on the structure of health and how this impacts queer young women's understandings and experiences of "good" sexual citizenship. I suggest that, despite positioning themselves as "ordinary" individuals, when it comes to sex education, "safe sex", and healthcare access participants are not "just like everyone else." In Chapter 4, participants found their school-based SRE biomedical, fear-based, and heteronormative. Biomedical definitions of "safe sex" result in greater awareness of safer sex with men, while reducing queer health literacy. In Chapter 5, despite portraying themselves as responsible and informed sexual actors and health consumers, participants are unsure how to negotiate safer sexual practices with women. I argue that the lack of language with which to discuss safer sex between women stems from inaccurate, heterosexist assumptions about STI risk and queer women's sexual practices. Therefore, greater discussion of queer women's sexual health is needed to challenge these heteronormative cultural understandings of safer sex that erase queer women and to establish safer sex and health screening as part of queer sexual scripts.

Healthcare plays a central role in participants' understandings of "good" sexual citizenship. However, although young women are positioned in neoliberal health discourse as responsible sexual actors and health consumers, in Chapter 6, I observe that identifying as bisexual or queer limits participants' perceived abilities to receive sensitive, quality healthcare in Tasmania, with many preferring to not disclose their identity to healthcare providers for fear of discrimination. These experiences problematise post-feminist and post-gay narratives that erase the structural forces shaping rural queer women's experiences and ignore the tangible effects of place on sexual citizenship, health, and wellbeing. I argue that it is through these attempts to engage with heterosexist systems (e.g. education, health) that participants' queerness challenges the neoliberal politics of normalisation. This causes the women to engage in "disidentification" as a survival strategy for navigating these systems, which I suggest is a key aspect of queer sexual citizenship.

Throughout this thesis, I have drawn on Jose Esteban Muñoz's (1999: 11) notion of "disidentification" to explain the ways in which queer young women negotiate space between homonormative, post-feminist gender and sexuality politics and lived experiences of queerness. Participant narratives reveal that queer young women engage in disidentificatory work as a survival mechanism in the face of heterosexist systems. Participants also describe experiences in which neoliberal ideologies paradoxically allow for a proliferation of increasingly specific queer identities, while simultaneously reducing those identities when it comes to engaging with social systems. Thus I argue that participants' reflexive identity politics, their negotiation of complex, competing gendered sexual scripts, and their navigation of sexual healthcare all point to an emerging mode of post-feminist queer sexual citizenship that, in the spirit of disidentification, engages aspects of homonormativity and post-feminism, while simultaneously offering scope for critical resistance.

Taking an intersectional approach throughout this thesis, I also highlight participants' multiple subject positions. It is important to recognise that the

participants' post-identity politics stem from positions of privilege. As Riggs (2010: 345) outlines, "'moving beyond' identity politics potentially functions to dismiss the fact that only certain groups (middle class, white queers) have benefited from the rights secured by identity politics." Therefore, as white, middle class, young women, participants are able to claim "ordinariness" in ways not available to queer and trans people of colour in Australia. Despite their experiences of marginalisation as rural queer women, participants' experiences are still mediated by unconscious middle class, white privilege. The participants' lack of intersectional gaze is a product of post-feminism and demonstrates how thinking with intersectionality challenges the neoliberal politics of homonormativity. This highlights the ongoing problem of scholarship that centres white, middle class, urban queer subjects whose disidentifications are couched in a depoliticised, privileged standpoint.

Contribution and Significance

This thesis makes a timely and critical intervention into queer theory and post-feminism by examining the role of neoliberalism in contemporary queer identity and health politics. Building on existing scholarship in this area, this unique research examines how both post-feminism and homonormativity shape queer young women's lives. Making the connection between post-feminism and homonormativity is a significant theoretical contribution to feminist sociology and gender and sexuality studies because it builds on existing work on neoliberalism and queer sexual citizenship while offering a critical new way to theorise young women's experiences of gender and sexuality. For example, I encourage queer theorists and anti-neoliberal scholars to consider the role of post-feminism in queer sexual citizenship and neoliberal identity politics. In doing so, this thesis contributes to existing scholarly debates by conceptualising a new form of queer post-feminist sexual citizenship, offering a theoretical tool with which to re-examine, interrogate, and re-imagine queerness, identity, and health politics under neoliberalism.

This thesis also extends current theoretical perspectives on post-feminism and

homonormativity by examining how they apply in the rural Australian context. It is through sexual healthcare that Tasmanian queer young women come to grapple, not only with the structural barriers, but also with conceptual barriers precipitated by their identities and their geographical location. I argue that participant disidentifications are strategic in the Tasmanian context where access to healthcare is already limited, especially in rural areas, with LGBTIQ health merely posing another potential barrier. This suggests that in rural spaces homonormativity may not extend to bisexual and queer young women in the same way as gay and lesbian urban populations and Global North. This also highlights a fault in the notion of homonormativity for queer women, as the underlying hetero-patriarchy of neoliberalism inherently fails to normalise their identities, merely offering conditional acceptance in return for depoliticised compliance and invisibility (see Duggan 2002; McRobbie 2009; Richardson 2005). Therefore, this thesis offers new critiques of homonormativity and post-feminism and identifies the need for greater consideration of how these concepts are theorised and in what context.

Finally, this thesis is significant for empirical sociological, feminist, and public health scholarship because it contributes to addressing the dearth of Australian research on rural queer women's health. Specifically, this thesis provides insight into the under-researched sexual health experiences of bisexual and queer young women. There is limited sociological research examining bisexual and queer young women's experiences of sexuality and sexual health in isolation from lesbians. Gaining a greater understanding of bisexual and queer women's experiences will advance scholarship on identity and plurisexuality, combat bi-erasure in theory and practice, and inform more inclusive health and human services. In this thesis, I show how gendered sexual scripts shape queer young women's understandings of safe sex and perceptions of risk in different sexual contexts, with significant implications for sexual health promotion and healthcare provision. Given bisexual and queer women's high rates of mental and sexual health risk, qualitative research in this area is crucial for understanding and addressing these disparities. Furthermore, as the majority of Australian LGBTIQ health research is conducted in urban settings, this thesis

makes a significant contribution as the first qualitative study of Tasmanian queer women. As the first study of its kind, this research has important implications for lesbian, bisexual, and queer women's health throughout Australia.

Policy Recommendations

Understanding how queer young women construct meaning around identity has important implications for health research, policy, and practice. As I discussed in Chapter 2, this research was conducted with a queer, feminist methodology, which prioritises research ethics and integrity and a commitment to furthering social justice through research. All participants in this study hoped that sharing their personal experiences could bring about social change. Through their disidentifications with dominant modes of (hetero)sexual citizenship and health consumption, participant accounts importantly demonstrate the need for education, public health promotion, and medical practice that engage with queer women's lived experiences in more meaningful, inclusive ways. With this in mind, I have identified several policy implications informed by the research findings.

A key recommendation resulting from this research is that lesbian, bisexual, and queer women's health should be more comprehensively included in mainstream women's health policies nationally. As I argued in Chapter 1, queer women's diverse health experiences, needs, and concerns are invisible in public health discourse. Queer women's health is either subsumed under broader LGBTIQ health initiatives that primarily focus on men's health, or implicitly included in "women's health" with little acknowledgment of the specific needs of queer women. This thesis demonstrates that the erasure and lack of awareness of queer women's health at a policy level has significant implications for individual women's wellbeing, for community health literacy, and for inclusive health systems. To address this, additional funding is required for specialist support services for lesbian, bisexual, and queer women and further research is required to drive evidence-based policy and service provision nationally. Australian public health policy, practice, and research could also be significantly improved

in this area by incorporating more intersectional perspectives. As Bauer (2014) outlines, intersectionality can enrich public health by drawing greater attention to the variety of interrelated social factors that produce health inequalities.

My findings reveal that mainstream health and human services are insufficiently inclusive of LGBTIQ patients, in particular bisexual and queer young women and transgender, non-binary, and gender non-conforming populations. Findings indicate the need for greater awareness and application of LGBTIQ-inclusive practice policies and procedures throughout health and human service provision nationally. In addition, this research demonstrates the importance of intersectionality and bisexual awareness to providers already focused on LGBTIQ health. For instance, I found that while rural health providers may be aware of gay and lesbian inclusive practices, greater improved awareness is needed around bisexual and queer women's specific experiences and the intersections of these with other aspects of identity (e.g. gender expression, race, class, rurality).

Drawing on recommendations from GP participants, mainstreaming LGBTIQ-inclusive care requires a multi-layered approach. In line with the recommendations of the RACGP (2016; SG16), more comprehensive LGBTIQ-awareness training is needed in Australian medical schools. However, rather than compartmentalising the entirety of "LGBTIQ health" into a single unit or assessment task, health issues pertaining to LGBTIQ populations, particularly under-represented groups such as women, trans, non-binary and intersex patients, should be integrated at multiple points throughout the medical curriculum and assessment at all year levels and specialisations. Greater focus on building communication skills through experiential learning with diverse patient populations is also required. Tailoring the medical curriculum to promote nation-wide mainstreaming of affirmative and inclusive healthcare for LGBTIQ patients would significantly improve health outcomes and contribute to addressing the health disparities faced by LGBTIQ communities.

This research also points to the need for improved vocational training

opportunities and resources for healthcare providers. While medical students and GP registrars may now receive more cultural competency and LGBTIQ-inclusivity training in universities, existing GPs and other healthcare providers require ongoing training in this area in order to mainstream inclusive practices. GPs identify in-service information sessions and online webinars as potentially useful methods of engaging doctors and clinic staff in equity and diversity issues. However, given the high workloads and professional isolation reported by practitioners in this study, any resources and training should be accessible, innovative, and practical within GP workloads. State government departments (e.g. Department of Health and Human Services) are well placed to fund and collaborate with LGBTIQ community organisations to provide these resources for the health sector.

This research also has implications for education policy. In line with previous Australian research (see Farrelly et al. 2007; Senior et al. 2014; Shannon 2016; Simpson et al. 2017; Winckle 2008), findings demonstrate the importance of comprehensive, holistic, and inclusive approaches to SRE. None of the participants in this study believe that the SRE received in school adequately prepared them for safer sex in adulthood. The omission of learning materials about LGBTIQ identities, experiences, and sexual health disadvantages queer young women's educational outcomes and sexual health literacy. I suggest that bisexual and queer young women would be more effectively engaged in SRE classrooms if SRE was reimagined as a form of civic training, incorporating the notion of sexual citizenship, which considers sexual self-efficacy to be an essential aspect of civic engagement (see Illes 2012). In addition, following the National defunding of the Safe Schools Coalition in 2017, a review of how Australian public schools approach LGBTIQ inclusivity and other equity and diversity issues would significantly benefit youth mental health and educational outcomes in the future.

Following improvements to SRE in schools, findings also highlight the need for improved public health promotion specifically targeting young women's reduced sexual health literacy. In particular, I identify Australian public health promotion

must be more accessible and inclusive of bisexual and queer young women. Insufficient targeting of sexual safety messages and a dearth of health promotion materials for bisexual and queer women contributes to a poorer uptake of safer sexual practices among these groups. Therefore, in line with Richters and Clayton (2010: 104), I argue for greater promotion and awareness of non-latex sexual risk reduction strategies for queer women (e.g. discussion of consent and health status between sexual partners, hand hygiene and toy care, and routine sexual health screening). State Governments, LGBTIQ organisations, and health centres could deliver such interventions through innovative health promotion and community engagement. For example, the AIDS Council of New South Wales' sexual health website (iloveclaude.com) uses an art-based approach to sexual health promotion for "sexually adventurous women across different ages, geographical locations, cultural backgrounds and sexual identities" (AIDS Council of New South Wales 2014). This initiative promotes queer women's sexual health and explores alternative safer sexual scripts through creative practice. This website is one way in which innovative, sex-positive health interventions targeting queer women can be delivered in Australia and internationally.

The lack of comparable studies of rural bisexual and queer young women in Australia highlights the importance of this research and its implications. Throughout this thesis, I identify several structural and conceptual barriers to health, education, and social services experienced by rural queer communities. Geographical isolation also impacts the service providers supporting these communities. Previous studies indicate that rural queer women experience greater health disparities, increased mental health risk, low sexual health literacy and reduced access to inclusive services. While the present study regrettably does not include the experiences of LGBTIQ Indigenous Australians, there is a growing body of evidence to suggest that these health disparities are significantly exacerbated among these groups, especially in rural and remote areas. Subsequently, additional resources and social services are critical for rural LGBTIQ communities nationally. In particular, there is a significant need for more accessible and inclusive health services in rural areas and for rural

healthcare providers to be more aware of the specific needs of these communities. Public health promotion and sexual health resources must also be made accessible for rural queer communities. Previous Australian research suggests social media plays an increasingly central role in rural LGBTIQ sexual cultures (e.g. relationships, dating, hook-ups, and friendship) (see Hillier et al., 2010; Lea et al., 2015; Robinson et al., 2014). Therefore, social media may be a pertinent mechanism for delivering sexual health information to rural queer women who may face geospatial barriers to accessing inclusive health services and information.

In addition to the broader implications outlined in this section, this study also has several implications for Tasmania. This thesis calls for mainstream Tasmanian health and human services to be more explicitly inclusive of lesbian, bisexual and queer women's health. Participants were often unsure which Tasmanian health services are LGBTIQ-inclusive. This demonstrates the need for services to more openly advertise a commitment to inclusive practice. I argue that the establishment of an LGBTIQ-inclusive practice accreditation process like GLHV's Rainbow Tick initiative would significantly improve LGBTIQ Tasmanians' health outcomes and satisfaction with care. It could work alongside the Rainbow Tasmania Tourism Accreditation scheme, while adapting the Rainbow Tick model to Tasmanian health and human services. Furthermore, additional resources specific to inclusive health service provision in rural Tasmania would significantly improve patient outcomes in these areas. Tasmanian LGBTIQ education service *Working It Out* currently offers professional learning for the health and education sectors. However, my findings suggest that further support is needed to extend these services.

A key recommendation of this study is that increased State Government funding for Tasmanian LGBTIQ community organisations and social services is necessary to address persisting health disparities and discrimination. This is especially the case in the state's Northern rural areas where services like Working It Out are limited, despite the complex needs of those communities. Increased funding is required to enable such services to expand to be more inclusive of diverse client

needs. For example, participants in this study indicate that Tasmanian services could be more explicitly inclusive of bisexual, pansexual, queer, and non-binary young people. The young people I spoke to call for increased and ongoing community engagement that includes diverse young people and for social services to remain accountable and attuned to the community's needs. As I outline in the next section, further research is required to inform many of these necessary developments.

Recommendations for Future Research

This thesis uniquely contributes to theoretical perspectives in gender and sexuality studies and to empirical sociological studies of bisexual and queer women's sexual health. However, additional research is required to build on the findings of this study.

As contemporary neoliberal and post-feminist framings of gender and sexuality influence young women's identities, it is important for scholarship to make sense of these developments. A key contribution of this thesis is the theoretical connections I draw between post-feminism and homonormativity. Because a broader exploration of the theoretical and political implications of this connection is beyond the scope of this thesis, I encourage further theoretical and empirical work to expand on this concept. More theoretical considerations of how neoliberalism and post-feminism are specifically deployed in the Australian context will expand scholarship and research capacity in this area. I encourage other Australian feminist and queer scholars to consider how Muñoz's work may apply to gender, sexuality, and race in the Australian context. Applying an intersectional queer feminist approach to this research has heightened my awareness of how identity politics and diversity operate in Australia and I hope scholars continue to critically engage with this work in the future.

To inform the implementation and ongoing improvement of LGBTIQ affirmative healthcare, additional exploratory research is needed to build on this study's findings. While this study provides a qualitative snapshot of a small sample of

Tasmanian GPs' approaches to LGBTIQ-inclusivity, a larger survey of Australian healthcare providers' knowledge and attitudes towards LGBTIQ health would expand knowledge of this area. Additional work is also required to examine Australian medical students' knowledge and attitudes towards LGBTIQ patients in order to assess the effectiveness and inclusivity of university curricula. This work is important for developing and mainstreaming inclusive practice policies in Australian health services and integrating principles of LGBTIQ-affirmative care into medical training and policy.

Further studies of queer women's experiences in rural Australia would make an important contribution to the fields of LGBTIQ studies and rural sociology. Participants in this study identify differences in LGBTIQ experience and cultures between Tasmania and mainland Australia. Thus, comparative research across these sites might illuminate the disparities LGBTIQ Tasmanians face compared to communities in metropolitan areas. Further research focused on transgender and non-binary people's experiences in rural Australia is similarly necessary. Finally, as this study and others like it focus on white, middle class queers, future research might explore the experiences and needs of queer communities of colour, with particular focus on the intersections of race/ethnicity and queerness in Australia.

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Appendices

Appendix A: Recruitment Advertisements

The Queer Sexual Citizen: Exploring sexual health in Tasmania

6 October 2015 ·

Do you identify as a woman?
Are you same gender attracted or identify as LGBTIQ? (e.g. you might identify as gay, lesbian, bisexual, pansexual, transgender, intersex, queer, non-binary and many more!)

Would you like to share your experiences around gender, sexuality and sexual health?

I am now looking for participants who are 18-24 year old women who identify as LGBTIQ or same gender attracted who are willing to discuss their experiences of sexual health in Tasmania. For example, I would like to ask you about how you understand 'safe sex,' relationships and identity as an LGBTIQ young person. I am also interested to hear your views on the quality of health service provision for LGBTIQ Tasmanians.

If you are interested to know more and would like to take part, I welcome you to contact me, Ruby Grant, via private message to this page or you can email me at rfgrant@utas.edu.au.
You can also call me on 6226 1556.

If you know someone who may be interested to take part, please share this post in your networks, as it would be great to reach as many people as possible.

Appendix B: Recruitment Advertisement

Image: Voula Pleonie, Planet Pink Design

Do you identify as a woman?
(Or Non-binary, assigned female at birth)

Are you same gender attracted or identify as LGBTIQ?
(e.g you might identify as gay, lesbian, bisexual, pansexual, transgender, intersex, queer and many more!)

Would you like to share your experiences around gender, sexuality and sexual health?

I am looking for participants who are 18-24 year old women who identify as LGBTIQ or same gender attracted and willing to share their experiences for my PhD research project on LGBTIQ young women's sexual health in Tasmania. Participation would involve one interview (up to 1 hour).

For more information, contact:

Ruby Grant

University of Tasmania
School of Social Sciences
Private Bag 22, Hobart TAS 7000
E: **rfgrant@utas.edu.au**
W:
www.facebook.com/tas.lgbtiq.study
T: (03) 6226 1556

HREC REF: H15217

Appendix C: Information Sheet (Women)

Information Sheet:
Exploring Same Gender Attracted Young Women's Experiences of Sexual Health in Tasmania

You are invited to participate in a research study that aims to investigate same gender attracted young women's experiences and understandings of gender, sexuality and sexual health in Tasmania. This study is being conducted by Ruby Grant as part of her doctoral research in Sociology at the University of Tasmania, and is being supervised by Dr. Meredith Nash, Dr. Emily Hansen and Prof. Imelda Whelehan.

What is the purpose of this study?

There is limited research on same gender attracted women's sexual health in Australia. This study seeks to address this by exploring how same gender attracted young women understand, negotiate and experience 'safe sex' and sexual health in Tasmania and how this factors into their experiences of gender, sexuality and identity.

Why have I been invited to participate?

You have been invited to participate because you are between the ages of 18 and 24, currently identify as a woman, live in Tasmania, and you are 'same gender attracted.' For example, you may identify as gay, lesbian, bisexual, pansexual, transgender, non-binary, queer and many more.

What will I be asked to do?

If you choose to participate in this study you will be invited to take part in one interview about your experiences of gender, sexuality and sexual health in Tasmania.

The interview will take place in a location convenient for you and will last for approximately one hour. At the interview you will be asked to complete a voluntary short questionnaire about yourself (age, education, relationship status), then we will talk about your experiences. For instance, I would like to ask you about how you understand 'safe sex,' relationships and identity as an LGBTIQ young person. I am also interested to hear your views on the quality of health service provision for LGBTIQ Tasmanians.

With your consent, our interview will be audio recorded and transcribed for analysis. Following our interview you will have the opportunity to provide feedback on the experience and you are welcome to let me know if there is anything else you would like to add. All information provided will be treated confidentially, accessible only to the researcher and used only for the purpose of this project. All data will be 'de-identified' and you will be asked to select a pseudonym (nickname) to ensure your anonymity in any reporting of this project.

Are there any possible benefits from participation in this study?

This project aims to benefit the wider community by raising awareness about LGBTIQ women's sexual health and by informing social supports, education, healthcare and public policies that impact LGBTIQ women. By participating, you may benefit from the opportunity

for your voice to be heard on issues of importance to women identifying LGBTIQ young people in Tasmania.

Are there any possible risks from participation in this study?

During interviews some people may experience discomfort if talking about difficult memories. You will not be pressed to discuss anything that makes you uncomfortable. If you are uncomfortable in the interview, you are welcome to pause, postpone or terminate your involvement at any point without question or consequence. Please be aware of these free, confidential counseling and support services that are available to you:

Working It Out http://www.workingitout.org.au/ http://beingproud.org.au/
Ph: South – 6231 1200 North & North West – 04 .
Working It Out is Tasmania's gender and sexuality support service, providing state-wide peer support groups and private counseling services.

Lifeline https://www.lifeline.org.au
Ph: 13 11 14
Lifeline is a national 24 hour crisis support hotline providing counseling and support for people of all walks of life.

Q Life https://qlife.org.au/ **Ph: 1800 184 527**
Q Life provides nation-wide LGBTIQ counseling and peer support via telephone and online chat.

What if I change my mind during or after the study?

Participation in this study is voluntary and there are no consequences should you decide not to participate. This will not affect your relationship with the University of Tasmania or any organisation or group where you heard about this project. If you change your mind and wish to withdraw during or after the study, any information you have provided will not be used in the project.

What will happen to the information when this study is over?

Once the study is over, hard and digital copies of interview transcripts and recordings will be kept in a secure location in the Social Sciences department of the University of Tasmania in Hobart. With your consent, data will be archived for use in future publications, otherwise it will be destroyed after 7 years. I will treat your information in a confidential manner, restricting access to any identifiable information to myself.

How will the results of the study be published?

The results of this study will be published in my PhD thesis, academic journal articles, online articles, conference presentations and, potentially, a book. You can keep up to date with the progress, findings and any publications resulting from this study by visiting the Facebook page: https://www.facebook.com/tas.lgbtiq.study.

What if I have questions about this study?

If you have any further questions about this study I warmly encourage you to contact me, Ruby Grant, via email at rfgrant@utas.edu.au or by phone at: 6226 1556.

You may also contact my supervisor for this project, Dr. Meredith Nash, via email at Meredith.Nash@utas.edu.au or by phone at: 6226 2715.
This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on 6226 6254 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number H15217.

This information sheet is yours to keep. If you are satisfied that all your questions have been answered and you would like to be involved in this project, please contact me to arrange a time for our interview. Thank you for taking the time to read about my study.

Appendix D: Information Sheet (Practitioners)

Information Sheet:
Exploring Same Sex Attracted Young Women's Experiences of Sexual Health in Tasmania

You are invited to participate in a research study that aims to investigate same sex attracted young women's experiences and understandings of gender, sexuality and sexual healthcare in Tasmania. This study is being conducted by Ruby Grant as part of her doctoral research in Sociology at the University of Tasmania, and is being supervised by Dr. Meredith Nash, Dr. Emily Hansen and Prof. Imelda Whelehan.

What is the purpose of this study?

There is limited research on same sex attracted women's sexual health in Australia. This study seeks to address this by exploring how same gender attracted young women understand, negotiate and experience 'safe sex' and sexual health in Tasmania.

Why have I been invited to participate?

You have been invited to participate because you are a general practitioner or healthcare practitioner with a specialisation, interest and/or experience in sexual health and have been identified as a practitioner dedicated to inclusive practice.

What will I be asked to do?

If you choose to participate in this study you will be invited to take part in a short interview about your experiences of providing healthcare to those who identify as lesbian, gay, bisexual, transgender and intersex (LGBTI).

The interview will take place in a location convenient for you and will last for 30 minutes. At the interview you will be asked to talk about your experiences. For instance, I would like to ask you about how you or your practice/clinic approaches inclusive practice for LGBTI patients and where you believe LGBTI healthcare provision in Tasmania could be improved.

With your consent, our interview will be audio recorded and transcribed for analysis. Following our interview you will have the opportunity to provide feedback on the experience and you are welcome to let me know if there is anything else you would like to add. All information provided will be treated confidentially, accessible only to the researcher and used only for the purpose of this project. All data will be 'de-identified' and you will be asked to select a pseudonym (nickname) to ensure your anonymity in any reporting of this project.

Are there any possible benefits from participation in this study?

This project aims to benefit the wider community by raising awareness about LGBTI women's sexual health and by informing social supports, education, healthcare and public policies that impact LGBTI women. By participating, you may benefit from the opportunity for your voice to be heard on issues of importance to women identifying LGBTI young people in Tasmania.

Are there any possible risks from participation in this study?

There are no risks anticipated as a result from your participation in this study. Any data you provide will be de-identified and treated confidentially.

What if I change my mind during or after the study?

Participation in this study is voluntary and there are no consequences should you decide not to participate. This will not affect your relationship with the University of Tasmania or any organisation or group where you heard about this project. If you change your mind and wish to withdraw during or after the study, any information you have provided will not be used in the project.

What will happen to the information when this study is over?

Once the study is over, hard and digital copies of interview transcripts and recordings will be kept in a secure location in the Social Sciences department of the University of Tasmania in Hobart. With your consent, data will be archived for use in future publications, otherwise it will be destroyed after 7 years. I will treat your information in a confidential manner, restricting access to any identifiable information to myself.

How will the results of the study be published?

The results of this study will be published in my PhD thesis, academic journal articles, online articles, conference presentations and, potentially, a book. You can keep up to date with the progress, findings and any publications resulting from this study by visiting the Facebook page: https://www.facebook.com/tas.lgbtiq.study.

What if I have questions about this study?

If you have any further questions about this study I warmly encourage you to contact me, Ruby Grant, via email at rfgrant@utas.edu.au or by phone at: 6226 1556.

You may also contact my supervisor for this project, Dr. Meredith Nash, via email at Meredith.Nash@utas.edu.au or by phone at: 6226 2715.
This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on 6226 6254 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number H15217.

This information sheet is yours to keep. If you are satisfied that all your questions have been answered and you would like to be involved in this project, please contact me to arrange a time for our interview. Thank you for taking the time to read about my study.

Appendix E: Consent Form (Women)

Consent Form:
Same Gender Attracted Young Women's Experiences of Sexual Health

This consent form is for interview participants who are taking part in this study on same gender attracted young women's experiences and understandings of sexual health in Tasmania.

Participation in this study is voluntary and on the basis of informed consent. You may withdraw participation and/or contributions to the study at any time with no consequences. Please read and complete this form once any and all of your questions about this study have been sufficiently addressed to indicate your consent to participate in this study.

1. I agree to take part in the research study named above.
2. I have read and understood the Information Sheet for this study.
3. The nature and possible effects of the study have been explained to me.
4. I understand that the study involves voluntary completion of a short demographic questionnaire.
5. I understand that the study involves participation in one interview lasting for approximately one hour where I will be invited to talk about my personal experiences and understandings of gender, sexuality and sexual health.
6. I am aware that the interview will be audio recorded by the researcher and that I will have a chance to review and provide feedback on the interview afterwards.
7. I understand that participation involves the risk that personal or sensitive topics around gender and sexuality may be discussed and this might involve the recollection of difficult memories that could cause mild discomfort. I have been informed that anything I discuss in the interview is confidential and that I will not be pressed to talk about anything that I do not wish to discuss. I have been provided with and am aware of counselling and support services relevant to my participation in this study.
8. I understand that all de-identified research data will be securely stored on the University of Tasmania premises for 7 years from the publication of the study results, and will then be destroyed unless I give permission for my data to be archived for future use.
   I agree to have my data archived:

   Yes _____ No _____
9. I understand that the researcher(s) will maintain confidentiality and that any information I supply to the researcher(s) will be used only for the purposes of the research.
10. I understand that the results of the study will be published so that I cannot be identified as a participant.
11. Any questions that I have asked have been answered to my satisfaction.
12. I understand that my participation is voluntary and that I may withdraw at any time without any effect.

Participant's name: _____

Participant's signature: _____

Date: _____

Statement by Investigator

I have explained the project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

The participant has received the Information Sheet where my details have been provided so participants have had the opportunity to contact me prior to consenting to participate in this project.

Investigator's name: _____

Investigator's signature: _____

Date: _____

Appendix F: Consent Form (Practitioners)

Consent Form:
Same Sex Attracted Young Women's Experiences of Sexual Health

This consent form is for interview participants and healthcare providers who are taking part in this study on same sex attracted young women's experiences and understandings of sexual health in Tasmania.

Participation in this study is voluntary and on the basis of informed consent. You may withdraw participation and/or contributions to the study at any time with no consequences. Please read and complete this form once any and all of your questions about this study have been sufficiently addressed to indicate your consent to participate in this study.

1. I agree to take part in the research study named above.
2. I have read and understood the Information Sheet for this study.
3. The nature and possible effects of the study have been explained to me.
4. I understand that the study involves participation in one interview lasting for approximately 30 minutes where I will be invited to talk about my experiences working with LGBTI patients as a healthcare practitioner.
5. I am aware that the interview will be audio recorded by the researcher and that I will have a chance to review and provide feedback on the interview afterwards.
6. I understand that all de-identified research data will be securely stored on the University of Tasmania premises for 7 years from the publication of the study results, and will then be destroyed unless I give permission for my data to be archived for future use.
   I agree to have my data archived:

   Yes _____ No _____
7. I understand that the researcher(s) will maintain confidentiality and that any information I supply to the researcher(s) will be used only for the purposes of the research.
8. I understand that the results of the study will be published so that I cannot be identified as a participant.
9. Any questions that I have asked have been answered to my satisfaction.
10. I understand that my participation is voluntary and that I may withdraw at any time without any effect.

Participant's name: _____

Participant's signature: _____

Date: _____

Statement by Investigator

I have explained the project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

The participant has received the Information Sheet where my details have been provided so participants have had the opportunity to contact me prior to consenting to participate in this project.

Investigator's name: _____

Investigator's signature: _____

Date: _____

Appendix G: Demographic Questionnaire (Women)

Same Gender Attracted Young Women's Sexual Health Experiences in Tasmania

Participant Questionnaire

Name & Pronouns

What would you like to be called in this study?
Please select a pseudonym (nickname) to be used in any reporting of this research to ensure your privacy/anonymity:

_____

Personal Pronouns (e.g. She/her/hers) :

_____

About You

Age:

_____

Where were you **born**? (circle what applies)

Australia

Overseas – Please specify _____

What is your home **postcode**? :

_____

Do you identify as **Aboriginal and/or Torres Strait Islander**? :

_____

How would you describe your **ethnicity/cultural background**? :

_____

What is your highest attained **education level**? (e.g. Year 10-12, TAFE, Bachelor/Associate degree, Masters, PhD):

_____

What is your **occupation**? (e.g. student, retail assistant) :

_____

How would you currently describe your **gender identity**?

_____

How would you currently describe your **sexuality**?

_____

How would you describe your **religious affiliation** (if any)? :

_____

How would you currently describe your **relationship status**? :

_____

How would you describe your current **living arrangements**? (e.g. share house with 3 friends, family home with parents) :

_____

Do you have any **children**? (if yes, please specify how many) :

_____

Appendix H: Letter of Ethics Approval

HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK

6 October 2015

Dr Meredith Nash
School of Social Sciences University of Tasmania

Student Researcher: Ruby Grant

Sent via email

Dear Dr Nash

Re: FULL ETHICS APPLICATION APPROVAL
Ethics Ref: **H0015217 - Exploring Same Gender Attracted Young Women's Sexual Health Experiences in Tasmania**

We are pleased to advise that the Tasmania Social Sciences Human Research Ethics Committee approved the above project on 5 October 2015.

This approval constitutes ethical clearance by the Tasmania Social Sciences Human Research Ethics Committee. The decision and authority to commence the associated research may be dependent on factors beyond the remit of the ethics review process. For example, your research may need ethics clearance from other organisations or review by your research governance coordinator or Head of Department. It is your responsibility to find out if the approval of other bodies or authorities is required. It is recommended that the proposed research should not commence until you have satisfied these requirements.

Please note that this approval is for four years and is conditional upon receipt of an annual Progress Report. Ethics approval for this project will lapse if a Progress Report is not submitted.

The following conditions apply to this approval. Failure to abide by these conditions may result in suspension or discontinuation of approval.

1. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval, to ensure the project is conducted as approved by the Ethics Committee, and to notify the Committee if any investigators are added to, or cease involvement with, the project.

A PARTNERSHIP PROGRAM IN CONJUNCTION WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Social Science Ethics Officer Private Bag 01 Hobart Tasmania 7001 Australia Tel: (03) 6226 2763 Fax: (03) 6226 7148 Katherine.Shaw@utas.edu.au

2. Complaints: If any complaints are received or ethical issues arise during the course of the project, investigators should advise the Executive Officer of the Ethics Committee on 03 6226 7479 or human.ethics@utas.edu.au.
3. Incidents or adverse effects: Investigators should notify the Ethics Committee immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
4. Amendments to Project: Modifications to the project must not proceed until approval is obtained from the Ethics Committee. Please submit an Amendment Form (available on our website) to notify the Ethics Committee of the proposed modifications.
5. Annual Report: Continued approval for this project is dependent on the submission of a Progress Report by the anniversary date of your approval. You will be sent a courtesy

reminder closer to this date. **Failure to submit a Progress Report will mean that ethics approval for this project will lapse.**

6. Final Report: A Final Report and a copy of any published material arising from the project, either in full or abstract, must be provided at the end of the project.

Yours sincerely

Katherine Shaw
Executive Officer
Tasmania Social Sciences HREC

A PARTNERSHIP PROGRAM IN CONJUNCTION WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Appendix I: Interview Guide (Women)

Interview Guide for Participants (Women)

Opening Discussion

How did you find out about the study?

Why were you interested to get involved?

Is there anything in particular about this topic that interests you that you would like to talk about today?

Gender

Would you like to start by telling me a little about your experiences growing up?

How would you currently describe your gender identity?

Have you always identified this way?

Where does your body come into this?

Sexuality

How would you currently describe your sexuality? What does this mean to you?

Can you tell me about how you came to identify this way?

Where do you feel your identity fits in the broader LGBTIQ community? Is this something that is important to you?

Have the majority of your sexual/romantic partners identified as the same/a similar or a different gender to you?

How has this factored into how you have understood your identity at different times?

Negotiations

Can you tell me about your experiences of sex education at school?

What kind of effect did this experience have on you?

Where have you gained most of your gender and/or sexual health information?

What does "safe sex" mean to you? What constitutes "risk"?

Is your idea of what is safe or what constitutes risk different with women identifying

partners?

What do you do to ensure and achieve sexual health?

Have partners shared your understandings/priorities around safe sex? How have you negotiated this with partners?

Do you think there is anything about being (X) that makes it harder for you to negotiate safe sex?

Health Experiences

Can you tell me about your initial experiences in healthcare contexts in Tasmania? For example, what has it been like in terms of accessing relevant services?

As a (X), do you feel comfortable discussing gender, sexuality and sexual health issues with your GP? Has this always been the case?

Have you found healthcare professionals in Tasmania to be knowledgeable and accepting of sexuality and gender diverse young people?

How do you think health services might be improved for LGBTIQ young people in Tasmania?

In your experiences, what have services done right? How do you think this might be built upon?

Closing Discussion

How could the public be better educated/informed about LGBTIQ sexual health needs, gender and sexuality? From your experiences, what would you tell them?

Is there anything we have talked about today that you would like to add to? Or something we haven't talked about that you believe is important?

Appendix J: Interview Guide (Practitioners)

Interview Guide for Participants (Practitioners)

Opening Discussion

What interested you about this study?

Tell me about the work that you do.

Would you say you have much experience working with LGBTI patients?

What is your impression of the standard of sexual health literacy and awareness among same sex attracted young women?

Inclusive Practice

Tell me about your overall approach to inclusive practice.

Does your clinic have an official position or policy on inclusive practice?

What does your clinic do to advertise that it is LGBTI-inclusive/friendly?

Can you give me an example of some of things you yourself do to provide inclusive care for LGBTI patients?

Does being a rural health centre pose any challenges to the provision of inclusive practice?

Consultation

Previous studies have indicated that lesbians and bisexual women are unlikely to disclose their identities to healthcare professionals for fear of discrimination. How do you facilitate self-disclosure in consultations with patients? Has this been effective?

Participants in my study have felt that communication barriers impacted their doctor-patient relationships – What is your experience of this?

Do you feel your medical training adequately prepared you for discussing sexuality and sexual health with patients?

As a health practitioner, how would you describe safe sex?

So far, in my study I have found low rates of safe sex practices among same sex attracted young women. While risk of STI transmission between women is low, how do you think GPs might empower LGBT patients to be active in terms of sexual health?